Journal of Human Sexuality

The *Journal of Human Sexuality* is an academic, peer-reviewed journal, an official publication of the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) and the NARTH Institute.

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Contents

Editor's Comments

This sixth volume of the *Journal of Human Sexuality* (*JHS*) is being published by the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) through the NARTH Institute, which houses the Alliance's clinical and research divisions and which published Volumes 1–5 of *JHS.* The Alliance for Therapeutic Choice and Scientific Integrity is a multidisciplinary professional and scientific organization dedicated to preserving the right of individuals to obtain the services of a therapist who honors their values; advocating for integrity and objectivity in social-science research; and ensuring that competent licensed, professional assistance is available for persons who experience unwanted homosexual (same-sex) attractions (SSA). The colleagues and supporters of the Alliance include practitioners, scholars, and researchers from many fields of the medical and mental health arts and sciences, as well as educational, religious, legal, and other community leaders and lay persons who are united in this shared organizational commitment.

In Service of Professional and Scientific Integrity

Volume 6 of *JHS* includes four articles and a book review written in the service of professional and scientific integrity. The first article—"A Call for the American Psychological Association to Recognize the Client with Unwanted Same-Sex Attractions" by Joseph Nicolosi—chronicles recent professional efforts by various members of the American Psychological Association (APA) to enlist the APA in supporting APA members engaged in offering psychological care to persons with unwanted same-sex attractions. The second article—"The Reincarnation of Shidlo and Shroeder (2002): New Studies Introduce Anti-SOCE Advocacy Research to the Next Generation" by Christopher Rosik—reviews a new wave of research attempting to document that "Sexual Orientation Change Efforts (SOCE)" may be harmful.

The third article—"Possible Factors in the Development of Same-Sex Attraction (SSA)" by Philip Sutton—reviews the factors that a number of clinicians and theorists think may influence or contribute to the development of same-sex attraction in some persons. The fourth article—"Prenatal Hormones Are Only a Minor Contributor to Male Brain Structure in Humans" by Neil Whitehead—reviews the research clarifying the limited influence epigenetic factors, specifically prenatal hormones, have on the development of the male brain and subsequent homosexuality and transgenderism. Finally, Christopher Rosik reviews James E. Phelan's 2014 book, "Successful Outcomes of Sexual Orientation Change Efforts: An Annotated Bibliography," which reviews more than half a century of documented positive outcomes in change-oriented psychotherapeutic intervention for unwanted same-sex attractions, behaviors, and identity.

In Defense of International Therapeutic Choice

Volume 5 of *JHS* contained a number of documents in a section entitled "In Defense of Client and Therapist Rights" that specifically addressed mental health professionals, public policymakers, legislators, and others, primarily in the United States, in support of the rights of licensed mental health professionals to offer—and their clients to receive—competent care. The section in Volume 6 entitled "In Defense of Therapeutic Choice" contains three documents intended for an international audience. In different ways, these documents reflect the advocacy that NARTH has made, and that the Alliance will continue to make, through its International Federation for Therapeutic Choice (IFTC) and by the Alliance president.

These documents include:

- The written IFTC intervention given at the Organization for Security and Cooperation in Europe (OSCE) Office of Democratic Institutions and Human Rights (ODIHR) 2013 Human Dimension Implementation Meeting in Warsaw, Poland.

- An IFTC response to parliamentary initiatives in the United Kingdom intended to prohibit offering professional care to persons with unwanted same-sex attraction.

- A response by then-NARTH president Christopher Rosik to a statement by the World Medical Association (WMA) that discredited professional attempts to assist clients who wish to modify same-sex attractions and behaviors, a statement that used arguments lacking in scientific integrity.

A Note for Readers and Potential Authors

Authors of articles, reviews, and official statements of *JHS* are held to the criteria of scientific integrity: namely, that what is written needs to be based on a fair reading and a responsible reporting of scientific data and demonstrable professional experience within the limits of a study's research design. While dedicated clinicians and scholars may differ in terms of their interpretations and proposed applications of research reports, the editors and peer reviewers of *JHS* documents work to ensure that *JHS* documents are based on an accurate understanding and description of *what* the respective research actually *does*—and *doesn't*—show. Readers of *JHS* are invited to review Volume 6, as well as past and future volumes, and to decide for themselves how well—or poorly—we have achieved the goal of scientific integrity in our own work.

Authors interested in submitting papers for future volumes should contact the editor at 1-888-364-4744 or via e-mail at info@narth.com

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Alliance for Therapeutic Choice and Scientific Integrity (ATCSI)

A Call for the American Psychological Association to Recognize the Client with Unwanted Same-Sex Attractions

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Abstract

Though the APA has endeavored to advocate for persons of various sexual orientations and gender identities, it has neglected to advocate for the homosexually oriented person who does not wish to claim a gay identity. This article discusses the possibility of decreasing unwanted homosexual attractions and exploring heterosexual potential and introduces the views of psychotherapists who support an individual's right to pursue such change. Those advocates include APA past presidents Nicholas Cummings and Robert Perloff. Other clinicians have published peer-reviewed data that provides supporting evidence for successful sexual-reorientation therapy. Four recommendations are proposed.

A Call for the American Psychological Association to Recognize the Client with Unwanted Same-Sex Attractions

> Psychological science cannot be held to a standard of political correctness by either liberals or conservatives. Let's not sell psychological science short. Rather, let's continually strive for a full and accurate accounting of ways in which our science can better inform public policy.
>
> —APA Past President Gerald Koocher (2006, p. 5)

In recent years, the American Psychological Association (APA) has taken a strong advocacy position in affirming persons of various sexual orientations and gender identities, including gays, lesbians, and bisexual and transgendered people. But there remains continued neglect for another sexual minority—the homosexually oriented person who does not wish to claim a gay identity. These men and women choose to deal with their same-sex attractions differently—not by embracing a gay self-label but by developing their heterosexual potential and diminishing what is for them a deeply dissatisfying and ego-dystonic erotic response.

The Possibility of Change

The APA states: "To date, there has been no scientifically adequate research to show that therapy aimed at changing sexual orientation (sometimes called reparative or conversion therapy) is safe or effective" (APA, 2008b). However, a large body of published literature demonstrates that some people can modify their homosexual orientation in a way that enables them to live satisfying heterosexual lives (Phelan, Whitehead, & Sutton, 2009). If the APA considers this entire body of classic literature as "scientifically inadequate," then practically every other psychotherapy approach in existence today also lacks sufficient evidence of its safety or effectiveness by APA standards.

Other public-policy statements by the APA have also discouraged the goal of change. "There is insufficient evidence to support the use of psychological interventions to change sexual orientation," said Judith M. Glassgold, PsyD, chair of the task force that issued the "Report of the A.P.A. Task Force on Appropriate Therapeutic Responses to Sexual Orientation" in August 2009. Glassgold states:

> The research methods [of recent studies] are inadequate to determine the effectiveness of these interventions. . . . At most, certain studies suggested that some individuals learned how to ignore or not act on their homosexual attractions. Yet, these studies did not indicate for whom this was possible, how long it lasted or its long-term mental health effects. (Mills, 2009)

The APA also warns about the possible harmful effects of reorientation therapy, postulating that the very existence of such therapy could pose "serious potential harm" to the health and well-being of lesbian, gay, and bisexual youth (Just the Facts Coalition, 2008). Yet in focusing only on the needs of gay-identified clients and failing to include individuals with unwanted same-sex attractions, psychologists have largely failed to respect the objectives of a valid subset of their clientele. These men and women believe that same-sex attractions can never be a part of their deepest identity, and they seek to decrease their homosexual attractions and explore their heterosexual potential.

I have heard numerous stories from my own clients and those of my colleagues about their difficulty finding a therapist who respects and supports their values. My clients say they were typically told by their therapists that change is neither possible nor desirable, and they were urged by the therapist to value (and embrace) a gay identity as a reflection of who they are and how they were made to be. Yet such a therapist-imposed

goal negates a client's right to autonomy and self-determination. It undermines the value systems of clients who believe that humanity was designed for gender-complementary coupling. These clients deeply resent this imposition by their therapists of what is to them an alien and unsatisfying worldview.

The NARTH Practice Guidelines recognize the importance of client autonomy and self-determination, especially in Guidelines 3 and 4 (NARTH, 2010). Ironically, the American Psychological Association (2008b) states, "Mental health professional organizations call on their members to respect a person's [client's] right to self-determination . . ." (p. 8). As previously stated, however, in my own clinical experience the rights of clients who have traditional worldviews on sex and gender have often been violated.

The reverberations from the APA discouraging homosexuals from seeking change are widespread. This is especially true since the APA sets the precedent for other mental health organizations, including the American Counseling Association, the National Association of Social Workers, and the American Association of Marriage and Family Therapists.

There is no doubt that reorientation therapy is not for every client. Most clients will likely choose to live out and embrace their same-sex attractions. Clearly, respect for client diversity and autonomy requires that gay-affirming therapy be available for such people. But reorientation therapy must also be offered for those who believe that their deepest identity can never be gay. Too often, clients distressed by their same-sex attractions are simply seen within the mental health profession as cases of "unresolved homophobia" that the therapist has a duty to "resolve" through an imposed change in worldview, values, and perhaps even religious affiliation (Herek, Gillis, & Cogan, 2009). In my experience, rather than being victims of a phobia or mental illness, most of these men and women have, in fact, freely chosen to live out a gender-complementary understanding of the meaning of gender and personal wholeness.

Who is the Nongay Homosexual?

Most psychologists know little if anything about this sexual minority. Typically, clients who enter sexual reorientation therapy are culturally and religiously conservative. Rosik (2003) notes that such clients usually hold ethical and philosophical worldviews that clearly distinguish them from the client population that seeks gay-affirming therapy. These men and women typically believe that homosexuality distorts and misuses our emotional and physical design as gendered beings who are meant to fulfill each other in gender-complementary ways. Their first goal in psychotherapy is to control their unwanted same-sex behaviors; their second is, if such proves possible, to live a traditional life of marriage with children.

Official policy assumes that anyone who seeks to modify his or her sexual orientation must simply be motivated by fear, ignorance, or a phobia (Rosik, 2003). But as one former client who had described himself before coming to therapy as a "gay man" explained to me "All we know is that this path of change is right for us. Because in it we have found the healing, acceptance, brotherhood and peace that we had really been seeking all along." After I informed one 16-year-old client in his first session of the APA position—that homosexuality is nonproblematic—he responded: "Homosexuality may not be a problem for the APA, but it is a problem for me!"

The APA's Practice Guideline 3 states that sexual orientation change efforts (SOCE) are both ineffective and potentially harmful:

> Reviews of the literature, spanning several decades, have consistently found that efforts to change sexual orientation were ineffective (APA, 2009a; Drescher, 2001; Haldeman, 1994; Murphy, 1992). . . . Therefore, in the current climate of evidence-based practice, SOCE cannot be recommended as effective treatment. Moreover, according to the APA policy on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (APA, 2009a), . . . the benefits reported by participants in

> sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation (p. 121).” (2011, p. 3)

These claims are contradicted, however, by reviews of the literature showing many peer-reviewed studies of therapeutic effectiveness as well as minimal evidence of harm (Phelan et al., 2009; Phelan, 2014; Whitehead, 2009).

A Brief History of Protests

During the APA Annual Convention in 2000, Dr. Robert Spitzer encountered a group of protesters in front of the convention hall. Their protest signs read “Help Us Change,” “Mental Health Rights for Ex-Gays,” and “Ex-Gay is O.K. Too.” As the architect of the 1973 decision to declassify homosexuality as a mental disorder, Spitzer was surprised by this encounter. His curiosity led to a dialogue with a few of the protesters, and he accepted an invitation to meet with them that night to hear their stories.

That meeting stimulated his interest in the experience of persons who had overcome unwanted same-sex attraction and culminated in a study conducted by Spitzer (2003) that was published in the *Archives of Sexual Behavior*. Spitzer found 200 men and women who had successfully transitioned out of homosexuality to heterosexuality. His study concluded that more than sexual behavior could be altered: “This study provides evidence that some gay men and lesbians are able to also change the core features of sexual orientation” (Spitzer, 2003, p. 415).

Summarizing the findings of his study, Spitzer (2003) concluded:

> In the self-selected sample, almost all of tithe participants reported substantial changes in the core aspects of sexual orientation, not merely overt behavior. Even individuals who made a less substantial change in sexual orientation reported that the therapy was extremely beneficial in a

> variety of ways. Change in sexual orientation should be seen as complex and on a continuum. Some people appear able to change only sexual orientation self-identity. Others appear also able to change overt sexual behavior. This study provides evidence that some gay men and lesbians are able to also change the core features of sexual orientation. (p. 415)

Ten years after the study was published, Spitzer had a change of heart and expressed doubts about the veracity of the reports he had documented; but without any new data or even a new review by him of the existing published data, that data still stands.

Six years later, at the 2006 APA conference in New Orleans, picketers again called on the conference attendees. About fifty formerly gay men and women carried signs with slogans such as, "APA, Please Help Us!" "Keep My Choice Ethical!" and "Diversity Includes Us!" (NARTH, 2006, p. 2). Most of the psychologists who spoke to these picketers expressed surprise that reorientation therapies were in any way restricted.

If a person is not satisfied being gay, why should he or she not have help to reduce unwanted homosexuality and develop heterosexual potential? Asked this very question during the town hall meeting at the 2006 APA conference, then-president Gerald Koocher agreed that this kind of help should be available. Highlighting the importance of client autonomy and self-determination, Dr. Koocher stated to the audience, "APA has no conflict with psychologists who help those distressed by unwanted homosexual attraction" (NARTH, 2006, p. 2). He stated that as long as there was no coercion and as long as proper informed consent was obtained, reorientation therapy could indeed be ethical.

At that convention, a petition signed by 75 members of the APA was presented to the leadership. It stated:

> We, the undersigned members of the American Psychological Association (APA), petition the President and Governance of APA to acknowledge, affirm and promote client autonomy, self-determination and diversity in matters relating to human sexual

adaptation. Further, we petition APA to support the individual's inalienable right to either claim a homosexual identity, or to pursue change in sexual adaptation in accordance with the ethical principles of APA and consistent with an individual's expressed value system. Finally, we petition APA to recognize, accept and provide opportunities for both gay-affirming therapists and reorientation therapists to express views and announce programs in *The Monitor* and other publications under APA's purview. (NARTH, 2008a)

At the 2008 APA convention in Boston, still more formerly homosexual men and women filled the town hall meeting—along with psychologists professionally committed to reorientation therapy—to once again call for the APA's acknowledgment of their position. Serving on the town hall panel were APA president Alan Kazdin, CEO Norman Anderson, and president-elect James Bray.

NARTH president A. Dean Byrd asked the panel if he, a conservative Christian psychologist with traditionalist views, was welcome in APA. Dr. Kazdin answered:

> APA would be at a great loss without you. We would suffer without you. . . . There are very few influences that have the scope and swath of influence as religion . . . without you, we would be ignoring a huge influence and huge part of reality. So not only do we want you, I would encourage you to leave the meeting and bring in more of your friends. We need a larger representation, not a smaller one.

Another man in the audience stood up to say, "I am a former homosexual and a master's level psychologist. I hope to dedicate my career to helping others like me. Is there a place for me within the APA?" In response, Dr. Kazdin implied that there was indeed a place, saying, "Diversity, for us, is not a matter of 'us.' There is diversity under all contexts, conditions, cultures, identity. And we need not only to understand it, but to have the advocates for it in our 'home.' . . . The question suggests we haven't done our job well . . . which is, if we do APA correctly, the question shouldn't come up."

APA's CEO Norman Anderson added:

> One of the big issues for us for some time now has been to make APA as welcoming to all points of view as possible. And most recently this was made most salient in a task force report put together in 2005 . . . and one of the principal things they focused on was how welcoming is APA, because some people had felt that it wasn't as welcoming as possible. So that was one of many motivations that moved us in the direction of hiring a diversity officer to actually take us to the next level of being a truly inclusive organization. We really have to put our aspirations in action and make sure we are what we say we are, and where we hope to be.
>
> Later that same day at a second town hall meeting, a graduate student introduced herself as a former lesbian who had benefited from psychotherapy. She expressed the same concern about disenfranchisement, saying, "I am interested in pursuing a career path that will allow me to help others like me, but I'm concerned that if I join the APA, I will be aligning myself with an organization that is governed more by politics than by science. What assurance can you offer me that this is not the case?" She too was assured that APA would be welcoming of ideological and worldview diversity (APA, 2008b).

Psychologists Who Support Freedom of Choice

Nicholas Cummings, a former president of the APA, has spoken out as a supporter of therapeutic choice. Cummings is a past president of Division 12 (Clinical) and Division 29 (Psychotherapy) and a recipient of psychology's Gold Medal for Lifetime Contributions to Practice. He has worked with hundreds of homosexually oriented men and women in his own practice—some of whom, he says, reoriented to heterosexuality when he worked

with them (NARTH, 2008b). Cummings supports the rights of future clients to receive such therapy, stating, "Attempting to characterize all sexual reorientation therapy as 'unethical' violates patient choice and gives an outside party a veto over patients' goals for their own treatment. A political agenda shouldn't prevent gays and lesbians who desire to change from making their own decisions" (Cummings, 2013).

A similar statement was made by another APA past president, Robert Perloff:

> The individual has the right to choose whether he or she will accept a gay identity. It is his or her choice, not that of an ideologically driven interest group. To discourage a psychotherapist from undertaking a client wishing to convert is anti-research, anti-scholarship, and antithetical to the quest for truth. (Nicolosi, 2006)

Brent Scharman, former president of the Utah Psychological Association, has asserted that all homosexual individuals should have the right to pursue change. He maintained that it is the client who should determine the direction of such treatment (Scharman, 1999). Martin Seligman, president of the APA in 1998, also has written in support of the reasonableness of offering such professional care. In his book *What You Can Change and What You Can't,* he cites research that is optimistic about change for those who have had fewer homosexual experiences and/or some bisexual feelings (Seligman, 2008).

In the symposium entitled "Destructive Trends in Mental Health" at the 2008 APA convention in Boston, former APA president Frank Farley noted that "political correctness has no place in the ethics code" (Byrd, 2008). Farley stated further that the "recent attempts to proscribe therapy aimed at sexual identity change are a misuse of the ethics process" (Byrd, 2008).

Writing in the journal *Psychotherapy*, Mark Yarhouse (1998) of Regent University also made a powerful case for the ethicality of reorientation therapy:

> Psychologists have an ethical responsibility to allow individuals to pursue treatment aimed at curbing experiences of same-sex attraction . . . not only because it affirms the clients' right to dignity, autonomy and agency . . . but also because it demonstrates regard for diversity. (p. 248)

Recommendations

Psychologists must respect the goals and objectives expressed by the client who is dissatisfied with his or her same-sex attraction and not simply dismiss such values as unresolved homophobia that the therapist has an obligation to change. As with all ethical treatment, there should be informed consent, and noncoercive techniques should be used that allow the client to follow his or her own life goals. The client's motivations must be examined, as some persons will feel ego-alien pressure from negative and coercive social, family, and religious influences. Childhood experiential factors, including those that influenced gender identity, should also be fully explored.

It is time for our professional associations to once again acknowledge the importance of client self-determination as the crowning principle of our code of ethics and to respect the Leona Tyler Principle, which states that all official APA position statements and resolutions must be based on rigorous science and demonstrable professional experience. The recognition of treatment options for individuals with unwanted same-sex attractions is not a threat to gay rights. Gay-rights advances need not—and, in fact, should not—obliterate the rights of any other group. Nor should political ideology be allowed to dominate the client-patient relationship. We should recall the advice of Sigmund Freud (1955), who wrote in 1919: "We refuse most emphatically to turn a patient . . . into our private property, to decide his fate for him, to force our own ideals upon him . . . in the service of a particular philosophy. In my opinion, this is . . . to use violence [upon the patient]" (pp. 164–165).

Therefore, I propose the following:

1. Those seeking to diminish their same-sex attractions and develop their heterosexual potential should receive the same respect for their goals as other marginalized groups, and therapists should not attempt to persuade them to abandon their values and worldviews.

2. Statements made by APA leaders must be backed by science and must be free from personal bias or political ideology. Committees chosen to study issues of sexual orientation should be philosophically diverse and include reorientation therapists. Such committees should not be composed primarily or entirely of those who are personally gay and committed to gay advocacy, as was the case with the group that wrote the 2009 *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation.*

3. Our profession should strive to understand its own cultural and professional biases—including those within our own association—that limit the understanding of the ex-gay experience and of people with traditionalist worldviews.

4. Psychologists should familiarize themselves with outside resources, both professional and lay, for individuals with unwanted same-sex attractions. The latter have the challenge of *coming out* twice: first as nonheterosexual, and later as heterosexually identified. During this process, they are often faced with stereotyping labels such as "homophobic," "hypocritical," "unenlightened," and "self-deceived." Like other sexual minorities, these clients face stigma and misunderstanding.

It is now time for the APA to move beyond mere words into tangible actions that reflect the embrace of a "pro-choice" position for clients who seek change in their sexual attractions and behaviors.

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The Reincarnation of Shidlo and Shroeder (2002): New Studies Introduce Anti-SOCE Advocacy Research to the Next Generation

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Abstract

This review examines three recent research studies that are being utilized professionally and politically to support broad claims of the ineffectiveness and harm of SOCE. These conclusions are deemed unjustifiable given a host of methodological problems. Paramount among these concerns are highly nonrepresentative samples, compromised outcome measures, and the confounding of the various forms of SOCE under study. As a consequence, generalizing the findings of these studies beyond the immediate participants is as problematic as claiming that the findings obtained from divorced clients who earlier participated in marital therapy provides a valid representation of outcomes for the therapeutic care of distressed marriages.

The Reincarnation of Shidlo and Shroeder (2002): New Studies Introduce Anti-SOCE Advocacy Research to the Next Generation

In what appears to be a renewed effort to supply an empirical foundation to legal and professional anti-SOCE (sexual orientation change efforts) activities, three new studies are being or have been published and are already being cited among gay and lesbian activists and their allies. Because this research is assuredly going to be uncritically trotted out in professional and lay discussions about SOCE, it is important that these studies be evaluated critically so that those concerned with clients' rights and therapeutic choice are knowledgeable about what these studies actually tell us. In what follows, I will analyze each study, providing a brief description and more in-depth critical discussion before closing with some general observations.

Flentje, Heck, and Cochran (2013)

Description of the Study

Flentje and colleagues (2013) set out to study what the process of reorientation therapy entails. Specifically, they wanted to find out about "typical modalities and interventions" of such psychological care. They surveyed 38 individuals who had gone through at least one "episode" of reorientation therapy and later reclaimed a LGB identity. According to the authors, the results revealed that frequently used reorientation interventions had a strong emphasis on religious practices—including negative messages about LGB individuals—and employed techniques that emphasized change over validation. Some unethical practices were also noted.

Among the professional and policy recommendations the authors draw from their conclusion is the endorsement of legal efforts, such as SB1172 in California, that prohibit licensed therapists from engaging in change-oriented intervention with minors (though as of this writing, the California law is still being litigated and therefore is not

in effect). Further, the authors explicitly suggest that therapists and clients pay close attention to when they might report licensed SOCE practitioners to state licensing boards: "Regardless of state legislation and the client's age at the time of the reorientation therapy experience, if ethically questionable or unethical behavior on the part of a licensed provider is identified, clients could be informed of and supported in their rights to report such behaviors to state licensing boards" (p. 274).

Analysis of the Study

Flentje and colleagues (2013) provide two paragraphs of limitations to their research. Yet any nonpartisan critique would, of necessity, make clear that a two-paragraph statement is woefully inadequate to provide sufficient insight into the scientific merit of this study. Most prominent of the concerns regarding the work of Flentje and colleagues are multiple facets of the study's sample.

Recruitment. Through various list-servs—that were were not fully described but were designed to locate "ex-ex-gays"—the researchers specifically sought individuals who identified as "ex-gays" at the time of their reorientation treatment and who, at the time of the data collection, had identified as lesbian, gay, or bisexual (LGB). Such a recruitment method introduced obvious bias into the study and probably insured that the researchers obtained the results for which they were looking.

Participants rated themselves as being "exclusively homosexual" (n = 22) or "predominately homosexual" (n = 16), indicating that the sample represented the most subjectively unalterable end of the same-sex attraction spectrum. In this context, it is worth remembering the concerns noted by the American Psychological Association's 2009 task force report, with the small modification of substituting "opponents" for "proponents," "succeeded" for "failed," and "benefited" for "harm" in the original text:

> Study respondents are often invited to participate in these studies by LMHP [licensed mental health professionals] who are [opponents]

> of SOCE, introducing unknown selection biases into the recruitment process . . . because study recruiters were open [opponents] 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. [Opponents] of these efforts may also have limited access to the research for former clients who were perceived to have [succeeded] in the intervention or who experienced it as [beneficial] (p. 34).

Perhaps the most effective way of clarifying the significance of this limitation is to provide a simple analogy. Imagine researchers who set out to investigate the modalities and interventions associated with martial therapy by recruiting a sample of former marital therapy clients who had subsequently divorced their spouses. How scientifically justified would it be for these researchers to offer their findings as a description of all marital therapy and to call for increased ethical and legal scrutiny of licensed therapists who offer such ineffective practices? Yet this is essentially parallel to how Flentje and colleagues approach their subject matter. The illegitimacy of such conclusions should be obvious to anyone who is fair-minded and not already predisposed against SOCE.

Treatment Setting and Provider Type. As if the recruitment problem was not bad enough, concerns multiply when the authors detail the setting and type of counselor participants reported as providing their SOCE. The majority of therapy "episodes" (56.1%) were provided by religious or pastoral counselors. Another 16.8% were administered by peer counselors. Only 34.6% of therapy "episodes" were actually provided by a licensed mental health professional. The failure of this study to disentangle religious providers from licensed therapists is a serious limitation that makes it inappropriate to draw from the findings any definitive conclusions regarding professionally conducted SOCE.

The authors do report that ethically questionable interventions occurred during 13 different courses of therapy reported by 10 different participants. Their discussion of these interventions may provide useful insight into how Flentje and colleagues (2013) framed their findings to cast the worst possible light on professionally conducted SOCE. They noted that nine of these 13 "episodes" where ethically problematic interventions occurred "included a licensed or licensable professional as one of the providers of therapy" (p. 266). Of course, the authors appear to have no way of knowing whether the licensed professional actually provided the ethically dubious intervention or whether it was provided by a religious counselor also involved in the participant's treatment. The authors then go on to describe a few of the ethically questionable practices, including aversive and holding therapies. The suspicion that these interventions were not provided by licensed professionals is given credence by the authors' earlier admission that no licensed therapist was described as utilizing aversion therapy, and the holding therapy was described as being provided by an "ex-gay layperson" to which the participant had been referred by his pastor.

Participant Demographics and SOCE Occurrence. Apart from being a very small (n = 38) and select sample, the sample composition was highly skewed toward male (n = 31) and Caucasian (n = 33) accounts and from a highly educated background (all but one having completed at least a four-year college education). The APA task force report (2009) noted similar concerns with the SOCE literature, raising particular concerns for generalizing findings to individuals who are less educated and less religious, not Caucasian, youth, and women.

Of interest to the question of SOCE harm, ten participants reported having attempted suicide. Of these, six participants reported a suicide attempt prior to their therapy, seven reported one or two suicide attempts during reorientation, and one indicated two suicide attempts following the conclusion of treatment. These findings suggest a significant portion of the sample was experiencing serious emotional distress

prior to SOCE, distress that cannot be definitively attributed to their therapy experience in the absence of longitudinal data.

The authors do acknowledge the fact that participant reports were retrospective and that this may have impacted the accuracy of their accounts. In fact, there is no indication in the study of how long ago participants actually sought SOCE, although it can be deduced from some of the statistics that at least some recollections are of SOCE that occurred at least 15 years prior. It is reasonable to assume that persons who decide to adopt a GLB identity following failed attempts to change their same-sex attractions and behaviors are not going to look back at those attempts with particular favor, and this could negatively color their recollections. The APA task force report (2009) expressed just such concerns with the SOCE literature, noting how retrospective accounts can introduce serious bias into research findings, and there is no reason to limit this caution to just favorable SOCE studies.

Another example of negative framing may be found in the authors' description of the costs and duration of participants' SOCE "episodes." Mean and median statistics suggest the inclusion of one or more significant outliers. Mean length in weeks of reorientation therapy was 40.5, though the median was only 26, with a standard deviation of 42.6. More problematic was the description of financial costs, with the mean total cost for a single episode of SOCE reported to be $2,195 and the median cost being $130, with a standard deviation of $5,267 and a range from $0 to $26,000. This suggests the presence of outliers as well as the ill-advised combining of intensive week or weekend SOCE experiences with SOCE provided via hourly psychotherapy sessions. Similarly, the costs of all SOCE per participant were $7,105 and the median costs $2,150, with a standard deviation of $11,384. These costs were reported to range between $0 and $52,000, again indicating at least one severe outlier.

It is curious that when the authors attempt to make the case against SOCE in the discussion section they choose to cite the inflated mean figure for total costs rather than

the more appropriate (and less dramatic) median statistic. Clearly, a more scientifically honest approach to the issue of cost would have been to use the median or to recalculate the statistics after removing the outliers.

Conclusion

Sample and other methodological limitations render the Flentje et al. (2013) research inappropriate for making any definitive claims about the general practice of SOCE, particularly in its professionally administered form. In this regard it resembles the earlier research by Shidlo and Schroeder (2002), whose methodological shortcomings it clearly repeats, only this time accompanied by unjustified implications regarding SOCE harm, benefit, and professional practice. Flentje and her colleagues sadly failed to be as forthcoming as Shidlo and Schroeder were when the latter acknowledged in italics that "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (p. 250).

Dehlin, Galliher, Bradshaw, Hyde, and Crowell (2014)

Description of the Study

A study by Dehlin and colleagues (2014) appears to be methodologically superior to the Flentje et al. (2013) research and is being published in an APA-affiliated journal. This research employed a web-based survey to contact 1,612 current or former members of The Church of Jesus Christ of Latter-day Saints (LDS, or Mormon) who had engaged in an effort to cope with (understand, accept, or change) their same-sex attractions. A diverse sample was sought, including participants who reported past engagement in change-oriented intervention. Results indicated that private and religious change methods were far more frequent than therapist-led or group-based efforts, and these methods were

reported to be the most damaging and least effective. When sexual orientation change was identified as a goal (compared to intervention where change was not a goal), reported effectiveness was lower for almost all interventions.

While some beneficial SOCE outcomes were noted (such as acceptance of same-sex attraction and reduced depression and anxiety), overall findings were said to support the conclusion that sexual orientation is highly resistant to explicit change attempts and that SOCE are overwhelmingly reported by participants to be either ineffective or damaging. The most ineffective/harmful methods cited by participants in this study were individual effort, church counseling, and personal righteousness (fasting, prayer, and scripture study). Generally, this study's conclusions were consistent with the APA task force's report: SOCE is judged as not likely to be effective, SOCE benefit is related to methods not specific to change-related intervention, and forms of therapy focused on helping the gay person accept a gay lifestyle for him/herself are endorsed.

Analysis of the Study

Although the Dehlin et al. (2014) study has the appearance of providing strong support for the APA's skeptical stance on SOCE effectiveness, attention to details of the study bring such a conclusion into question. Several aspects of the study's methodology and conclusions need to be discussed.

Author Affiliation. To their credit, the study's authors make clear that they are all "LGBTQ allies" who affirm the APA's position supporting religious beliefs and practices, and that all the authors "have been active in supporting the LGBTQ community, online, and national/international engagement." Four of the five authors were raised LDS, and two remain active in the church. All are said to work closely with LGBTQ Mormons in professional and/or personal roles. These disclosures do not include any indication as to how many of the authors, if any at all, had attempted change earlier in their lives, but it would not be surprising if some of them had personal experiences with failed SOCE.

Such personal commitments are not surprising and quite common among researchers in the study of sexual orientation. This raises the risk that the authors are known in some fashion by some of the participants, which can cause participants to respond in socially desirable ways (APA, 2009).

The authors' anti-SOCE affinities also increase the likelihood of groupthink and the risk of failing to recognize important alternatives, resulting in tainted conclusions and social-policy recommendations (Chambers, Schlenker, & Collisson, 2012; Redding, 2013). The only way around these difficulties is a bipartisan research program that brings together investigators from both sides of the issue, something that to date opponents of SOCE have shown no inclination of doing (Rosik, Jones, & Byrd, 2012).

Sample Recruitment. The importance of author affinities is also evidenced in evaluating how the authors obtained their sample. Dehlin and colleagues (2014) emphasize that they sought out a diverse sample by including recruitment through LDS groups that would be supportive of SOCE. Interestingly, the National Association for Research and Therapy of Homosexuality (NARTH) was not contacted as a source for soliciting LDS participants—a curious omission. In the final sample, 21% of participants were solicited through online and print media that were not particularly conservative sources (e.g., *Huffington Post*, Religion Dispatches.org, *Salt Lake Tribune*, and *San Francisco Chronicle*). Another 21% of the sample was obtained through LDS-affiliated LGBTQ support groups, purportedly across the spectrum of beliefs regarding SOCE. Unfortunately, the authors do not break down this figure by specific support group organization, which would have made transparent just how much their claims to have avoided recruitment bias were actually successful. What they did indicate was that Evergreen International (a group more favorable to SOCE) refused to advertise the study, and one is left wondering if the affinities of the authors had something to do with this decision. Word of mouth (electronic social media) led 47% of participants to involvement in the study, which, given the author affinities, cannot be assumed to be equally divided

among opponents of SOCE and those sympathetic to it. Finally, 5% of the sample was solicited through LGBTQ support organizations, which were described as being very helpful in promoting awareness of the study, which is not unconnected to questions about the potential bias introduced through word-of-mouth recruitment. In summary, despite Dehlin et al.'s promotion of their study as involving an ideologically diverse sample, the information the authors provide do not guarantee—and in fact raise serious questions about—the diversity of this sample in evaluating SOCE and generalizing participants' SOCE experiences.

Additional light may be shed on this concern by highlighting the fact that 25% of participants self-described as disaffiliated LDS and another 10% were reported to have been forced to leave the LDS church. In addition, 36% of participants were inactive church members. Only 29% were still actively engaged with their church. What this suggests is that the sample consisted overwhelmingly of participants who were moderately to highly disaffected with the LDS church, which again raises concerns about the representative nature of the sample and the response bias this disaffection may have introduced against SOCE specifically and conservative values in general. Add to this the concerns associated with retrospective, self-report surveys (APA, 2009) and SOCE experiences highly skewed (76%) toward the accounts of male participants, and there is justifiable concern with the reliability and generalizability of the study's findings.

Definition of Variables. Another questionable and outcome-biasing feature of Dehlin et al.'s study is likely to be the manner in which they defined (or operationalized) their primary outcome measure. Participants were asked to rate their SOCE experiences on a five-point scale, from 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, and 5 = *severely harmful*. This is a highly unusual rating scale in that it is anchored by terms that are actually measuring different dimensions—effectiveness and harm. I cannot think of another example where a key outcome measure was defined using terms that are not antonyms (opposites) but rather meshed-together

endpoints from two different qualities—in this case conflating harm and effectiveness. To be consistent with most research, Dehlin and colleagues should have provided participants with two scales—one anchored by *highly effective* on one end and *highly ineffective* on the other end and the other by *significantly beneficial* on one end and *significantly harmful* on the other.

Note also that the midpoint of the scale is *not effective*, which is far from the typical neutral rating one would expect to find at the center point of a scale. This also is hard to fathom and clearly promotes a biasing effect toward SOCE as lacking effectiveness. This is because of the well-known midpoint response bias, wherein respondents often tend to chose a middle response when they are rushing, when they are uncertain, or when they have no opinion. Far preferable for this research would have been seven-point scales for both effectiveness and harm that would have allowed for more nuanced responding (such as the inclusion of *slightly harmful* or *slightly beneficial* and *slightly effective* or *slightly ineffective* options) and included truly neutral midpoints (such as *neither harmful nor beneficial* and *neither effective nor ineffective)*. As it stands, the conflation of harm and effectiveness in the response scale used in this study creates significant uncertainties about what the results actually mean. Certainly, outcomes would have been more favorable had Dehlin and colleagues (2014) defined the midpoint as *not harmful* rather than *not effective*, which would have been an equally arbitrary methodological decision.

Ideological confounds are also quite possible in the authors' choice to measure psychosexual health in part through utilizing Rosenberg's (1965) measure of self-esteem. Some scales define their construct in a manner that is inherently biased against religious values (Rosik, 2007a, 2007b), which is always a methodological concern when surveying conservatively religious individuals. Consequently, scores may reflect differences between humanistic values and theistic beliefs (for example, elevation of the self versus the virtues of humility and self-negation) more than the construct purportedly assessed

by the instrument, which in the present case was self-esteem. Such appears to be the case with this measure of self-esteem, where research has suggested that when antireligious humanistic dimensions of the Rosenberg scale were statistically controlled, the self-esteem ratings of conservatively religious persons were significantly improved (Watson, Morris, & Hood, 1987). The implication for the Dehlin et al. (2014) study is the distinct possibility that self-esteem levels were suppressed and might actually have been higher than indicated for participants who remained conservatively religious and therefore were more likely to report positive SOCE experiences. As it stands, the authors reported that they failed to find significant quality of life or self-esteem differences between participants who had attempted SOCE and those who did not, a discovery not loudly trumpeted in the article.

Positive Outcomes. In spite of these problems with scale definitions and their potential biasing toward ineffective SOCE ratings, some SOCE methods actually did receive mildly positive endorsements. Of interest is the fact that these slightly positive ratings were found for therapist-led, group therapy, group retreat, and psychiatry methods, while personal righteousness, individual effort, and church counseling methods received slightly harmful ratings. Once again, given the scale ambiguities, we cannot be sure this average rating signifies less effectiveness or more harm. Psychotherapy was found to have moderate or greater effectiveness by 44% of respondents who sought it, with respective effectiveness ratings of 48% for psychiatry, 41% for group therapy, and 48% for group retreats. Of contextual importance is the finding that professional SOCE methods were reported far less frequently by participants than religiously oriented methods, meaning that aggregate results concerning change in Kinsey scores and psychosexual health likely provide an unrealistically negative view of professional SOCE.

Overrepresentation of Nonprofessional SOCE Methods. Dehlin and colleagues (2014) report that religious and private forms of SOCE were far more

prominently reported in their sample than were professional methods. Whereas 85% of participants indicated engaging in either religious or private individual SOCE methods, only 44% reported some form of therapist or group-led SOCE. Engaging in "personal righteousness" (such as prayer, fasting, studying scripture, or an improved relationship with Jesus) was reported twice as much as pursuing professional psychotherapy. Yet the authors report that group-related and therapist-led methods tended to be rated by participants as the more effective and least damaging forms of SOCE. Furthermore, SOCE "methods most frequently rated as 'effective' tended to be used the least and [for the] shortest duration, while methods rated most often as 'ineffective' tended to be used most frequently and for the longest duration" (p. 6). The authors also contend that this "effectiveness" represented not orientation change but orientation acceptance, decreased psychological distress, and improved family relationships.

It is worth mentioning here that Dehlin and colleagues (2014) speculate about the reliance of participants on private and religiously-oriented SOCE methods and suggest this may be due in part to the refusal of licensed therapists to engage in SOCE. This is a tragically ironic observation in that psychologists and other mental health professionals have abandoned religiously conservative persons with SSA conflicts who wish to pursue change. Rather than engage with therapists who respect their self-determined goals and are trained to provide SOCE with an awareness of professional and ethical issues, psychology may be forcing these individuals to "white knuckle" their struggle alone or rely on untrained religious practitioners, where the risk of harm may be significantly greater. Incredibly, if the present study's findings are to be believed, arguments offered in favor of California's proposed legal prohibition of SOCE with minors have specifically suggested licensed therapists refer these minors to religious counselors—a practice more likely to harm these minors than were these therapists to actually provide the SOCE.

This overrepresentation of purportedly ineffective/harmful individual (conducted alone by oneself) and religious-oriented SOCE methods makes the study's findings

regarding Kinsey ratings and psychosocial health inappropriate as a measure of professionally conducted SOCE. These general results summed over all SOCE forms therefore are likely to be skewed in an adverse direction, and again might conceal potential positive outcomes of professional SOCE.

Type of SOCE Provider. Another critical concern with the study by Dehlin and colleagues (2014) is the likelihood of provider confounds. In other words, the study combined religious and professional SOCE providers. The results (ambiguous as they may be already given the scaling problems) clearly implicated SOCE provided by religious authorities (such as LDS bishops) as being associated with greater ratings of harm as compared to SOCE provide by licensed therapists. While it would be understandable to conclude from such findings that conservative clergy or pastoral counselors may do more harm than good when working with persons with same-sex attraction struggles, such a conclusion would be a highly inappropriate generalization from this research. The reason for this has to do with how the LDS church selects its ecclesiastical leaders. The typical LDS church bishop does not obtain theological or pastoral graduate education but is instead chosen from among male members in good standing with the church who have shown themselves to be competent and successful with their families and vocations. Dehlin et al.'s results in this regard may well reflect the not particularly surprising discovery that religious individuals in conflict about their same-sex attractions are at a greater risk of harm when their SOCE provider is, for example, a plumber or a banker, however well-intended the provider might be.

Kinsey Ratings. Dehlin et al. (2014) indicate that individuals engaged in SOCE did not on average report different Kinsey attraction, behavior, and identity scores from participants who had not engaged in SOCE. Yet current ratings on these dimensions are not a direct measure of SOCE outcomes and do not tell us very much about the effects (or lack thereof) of the SOCE experience. Presumably, a significant period of time may have elapsed between the end of SOCE and the survey administration, and

many factors unrelated to SOCE could impact these ratings. Only a pre- and post-test design can take into account pre-SOCE levels of these dimensions and enable tentative conclusions about causality, as the authors admit: "It is not possible to determine causality and directionality of these relationships without the use of methodologies such as randomized clinical trials or longitudinal studies" (p. 10). What these ratings probably do reflect is that most of this sample (91%) had adopted a GLB identity since the time of their SOCE, a finding entirely consistent with participants being overwhelmingly disaffected (73%) with their church. This raises the same concerns noted above for Flentje et al.'s (2013) study of "ex-ex-gays."

Conclusion

While Dehlin et al.'s (2014) study is clearly an improvement over the Flentje et al. (2013) research, it nonetheless suffers from many of the same limitations and in this regard may be more pernicious, as the findings will certainly be offered by opponents as evidence of professionally conducted SOCE harm and ineffectiveness. Dehlin and colleagues encourage such a usage in their discussion about the study's implications for counseling, asserting that the findings support the APA and other professional associations' conclusions about SOCE and advocating for the LDS church and affiliated therapists to adopt acceptance-based forms of therapy.

Consideration of this critical review would instead suggest that the findings of Dehlin et al.'s (2014) study cannot be definitively or legitimately generalized beyond the sample population examined. It is a sample purported to be more representative but which, in fact, is overwhelmingly represented by currently LGB-identified persons who are disaffected with the LDS church and who most commonly engaged in SOCE alone or with religious leaders unlikely to have formal psychological or even pastoral training. Questionable measurement (scaling) of the outcome variable also raises questions about the internal validity of the findings. The results of Dehlin et al.'s study therefore may be

useful in anti-SOCE advocacy, but they do not shed much light on the risk of harm or effectiveness of SOCE offered by licensed mental health professionals. In fact, authors more sympathetic to SOCE might have argued that the data point to the need for religious conservatives with SSA conflicts to have greater access to professionally guided forms of SOCE. At most, Dehlin and colleagues have provided evidence that some prior participants of SOCE who are now opposed to the goals of SOCE may look back on their experience as harmful or not effective.

Bradshaw, Dehlin, Crowell, Galliher, and Bradshaw (2014)

Description of the Study

No doubt aware of the limitations of the Dehlin et al. (2014) study regarding therapist-led SOCE, this mostly same team of authors analyzed the subsample of respondents who reported participation in psychotherapy for their SSA conflicts. This sample was comprised of 868 individuals (672 men and 194 women). The authors reported that such counseling was largely ineffective, with less than 4% of participants reporting any modification of SSA, 42% indicating their change-oriented therapy was "not at all effective," and 37% finding it to have been moderately to severely harmful. Affirming psychotherapeutic approaches were often found to be beneficial in reducing depression, increasing self-esteem, and improving relationships. The authors conclude that there is a "very low likelihood" of sexual orientation modification and advise highly religious sexual minority persons to consider this before engaging in reorientation therapy.

Analysis of the Study

The Bradshaw et al. (2014) study is not a new study in the sense that it uses the same data set employed by Dehlin et al. (2014). Rather, it examines the specific subgroup

of participants who reported having engaged in SOCE via psychotherapy. This means that many of the methodological problems noted for Dehlin et al.'s research persist as well as a few new concerns.

Sampling Procedures. As noted above, the concerns associated with this research group's first study remain present for this article as well and in some cases are given further delineation. The overrepresentation of men and their experiences continues, with the added observation by the authors that the women participants showed great Kinsey scale variability and more bisexuality. Furthermore, male participants were three times more likely than women to make explicit statements that change had not occurred. The potentially biasing effect of a largely LDS-disaffected sample is suggested in the finding that participants no longer associated with the church were significantly more likely to describe their therapy experiences as "severely harmful." While this could signal a tendency to minimize harms suffered among those still trying to be faithful to the church, it could just as well reflect a tendency to emphasize harms by those who now feel an affinity to an LGB community that may be hostile to certain beliefs/practices of the LDS church related to sexuality in general and SOCE in particular.

Bradshaw et al. (2014) also observed that categorical change (change from no opposite-sex attraction to only opposite-sex attraction) was not reported by participants; rather, when change was indicated it was more toward bisexuality. Moreover, these authors noted that bisexuality was underrepresented in the sample. This is a concern in that bisexuality is likely to be more responsive to change-oriented intervention than an exclusively homosexual orientation (Whitehead & Whitehead, 2010), and this could have reduced reports of positive SOCE outcomes in comparison to what might have been obtained with a more representative sample. Finally, the likely recruitment problem favoring participants allied to GLB organizations and communities unsympathetic to SOCE continues to loom in the background of Bradshaw et al.'s work, making strong conclusions against change-oriented psychological care scientifically and professionally inadvisable.

Measurement Concerns. Outcomes are again measured with the problematic scale that conflates two different dimensions (harm and effectiveness). The discussion of these concerns noted above concerning the Dehlin et al. (2014) study will not be repeated here, but their salience can be seen in the author's report that 42% of psychotherapy SOCE participants viewed their experience as *not at all effective*, 21% as *moderately harmful*, and 16% as *severely harmful*. This reporting sounds as if the results are independently derived from two different measures, as they clearly should have been. The fact that they are taken from three neighboring points on a single scale certainly creates the likelihood of a loss of important nuance in the data, thereby unduly inflating participant ratings of harm and ineffectiveness in their evaluations of professional SOCE. Again, these outcomes surely would have been different had Bradshaw et al. (2014) defined the midpoint as *not at all harmful*.

It should also be mentioned that the authors indicate their survey took, on average, more than an hour to complete. This fact makes for a greater risk of significant midpoint response bias (which would bias the overall effectiveness rating downward) as participants seek to get through an unusually long survey process as quickly as possible.

In addition, Bradshaw et al. (2014) trichotomize the goals of psychotherapy-related SOCE into change, acceptance, and understanding. Yet these are by no means mutually exclusive goals, and it is reasonable to believe that most therapists providing SOCE are also promoting goals of acceptance (e.g., of the reality of clients' SSA) and understanding (e.g., promoting the clients' self-discovery of the origins of their SSA). Thus, this forced-choice categorization appears by definition to mischaracterize professional SOCE, again with a likely accompanying loss of data precision that could lend useful refinement to the study's findings.

Confounding of SOCE Forms. Another serious potential concern in Bradshaw et al.'s (2014) study is the admission by the authors that participants engaged on average in 3.7 additional forms of SOCE interventions. Moreover, "It became clear

that participants often viewed their SOCE holistically, as a composite of all the interventions in which they had engaged, including, especially, private efforts made concurrently with professional counseling" (p. 12). Thus participants engaged in multiple therapy efforts that were not differentiated in their overall rating scores. Open-ended responses suggested that some participants applied the outcome ratings narrowly to therapist-led SOCE, while others rated the benefit or harm of their experience across all SOCE forms utilized. Consequently, the results of this study cannot be reliably linked to professional SOCE, as they may well be adversely distorted by participants' evaluative inclusion of the more deleterious forms of SOCE in their ratings. To employ these ratings as a pure reflection of professional SOCE as Bradshaw et al. have done is to engage in scientifically unjustified speculation.

It is also possible that many of the 93 participants who reported an aversive therapy emphasis in their SOCE experienced this intervention in the context of religious forms of SOCE or engaged in it years ago when aversive treatments were common to a broad range of clinical concerns within the field of psychology. The fact that contemporary SOCE practitioners have long eschewed the use of aversive techniques with unwanted SSA (NARTH, 2010) would seem to make dubious the assumption that recent professional forms of SOCE are behind this figure. Furthermore, as noted previously, Flentje et al.'s (2013) study found that no aversive treatments were reported by participants in their professional SOCE experiences.

Additional Signs of Bias. While not a methodological issue per se, Bradshaw et al.'s (2014) discussion of SOCE provides not-so-subtle indications of their partisan sentiments. For example, Bradshaw and colleagues dismiss Spitzer's (2003) research, citing Spitzer's "repudiation" of his findings but fail to note that several of his participants subsequently affirmed their change and repudiated Spitzer's action (Armelli, Moose, Paulk, & Phelan, 2013). Similar to how the APA's (2009) task force report dismissed the Jones and Yarhouse (2011) study in a footnote, Dehlin et al. (2014), dismiss Jones and Yarhouse in a

sentence, despite this study's clearly more rigorous methodology. Bradshaw and colleagues seem eager to point out the demise of Exodus International and admissions of lack of change by its former president. This is a curious non sequitur in that Exodus was a religious ministry promoting religious forms of SOCE while the present article was addressing only SOCE delivered through licensed mental health providers. Finally, the authors reveal their etiological commitments when they affirm that SOCE requires a disregarding of the "large body of evidence" demonstrating "a biological origin for sexual orientation" (p. 24). Such a definitive commitment to biological origins is not in keeping with the current APA opinion (APA, 2008; Just the Facts Coalition, 2008), which states:

> There is *no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation*. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that *nature and nurture both play complex roles*. . . ." (APA, 2008; emphases added).

Conclusion

Bradshaw and colleagues (2014) conclude their article with the following statements:

> For adherents to this line of reasoning [i.e., that change can occur], the claim of a successful sexual orientation change by a few individuals is sufficient to generalize to the population at large. The clear evidence, however, is that dutiful long-term psychotherapeutic efforts to change are not successful and carry significant potential for serious harm, and that LGBQ Latter-day Saints find greater satisfaction in counseling approaches that result in acceptance or accommodation. (p. 24)

As is evident, the authors first create a straw argument whereby all SOCE proponents assume that change for some patients means all patients can change. They cite no literature to back up this accusation but then proceed to challenge this false portrayal by citing the results of their study. However, as I have attempted to make clear, this study's serious methodological weaknesses make the authors' broad generalizations scientifically unjustifiable. That Bradshaw and colleagues would make such unqualified conclusions places their work firmly within the advocacy research tradition of Shidlo and Schroeder (2002).

General Discussion

There is little doubt that some consumers of professional SOCE experience their therapy as ineffective and/or harmful. To state otherwise would be to claim a standard of outcome unattained by any other approach to psychological care (Lambert, 2013; Lambert & Ogles, 2004). Therapists who engage in SOCE no doubt find agreement in the desire to minimize the potential for harm and increase the likelihood of successful outcomes through a commitment to high ethical and practice standards. The issue in question, however, is the prevalence of harm and the degree of effectiveness in professional SOCE. I have offered here an admittedly critical review of three recent studies because is it likely the limitations of this research will be glossed over (if mentioned at all) by activists and professional mental health associations eager to demonize change-oriented care and further restrict therapeutic choice for clients with unwanted same-sex attractions.

While these studies do appear to document some experiences of harm and unsuccessful SOCE as well as suggest that nonprofessional forms of SOCE may carry a higher risk of adverse outcomes, an objective methodological analysis indicates that the findings simply cannot support any conclusions beyond these broad observations. In fact, were we to apply the overly rigorous methodological standards of the APA (2009)

task force to these studies, it would have to be concluded that they do not meaningfully advance the discussion on the issues of SOCE harm and effectiveness. Foremost in preventing this research from furthering our understanding of SOCE outcomes are sampling and measurement concerns that virtually guaranteed that reports of SOCE harm would be inflated and accounts of success would be suppressed.

The aforementioned analogy remains apt. The central limitations of these studies are captured well by imagining a project wherein researchers surveyed religiously conservative former marital therapy patients who had subsequently divorced in order to determine the treatment's effectiveness and harm and then used these results to make sweeping conclusions about this therapeutic modality. Would this be a fair and scientifically justified use of the findings? I might add that the marital therapist is not trying to cure an illness here, but rather is frequently attempting to help clients live their lives in a manner consistent with their religious beliefs about the sanctity of marriage (Dollahite, Hawkins, & Parr, 2012). Furthermore, these religious clients' deeply held moral values may lead them to remain in a distressful marriage and pursue therapy long after other clients would have opted for divorce. Yet the choices of such clients to seek marital therapy are not *ipso facto* assumed by the profession to be based on *internalized divorce-negativity* or *cultural maritalism* and thereby invalidated, despite the additional emotional stress that may come from remaining in their marriages. Outside of political advocacy calculations, an evenhanded scientific assessment (not to mention common sense) would suggest that professional SOCE clients and therapists be given a similar benefit of the doubt and allowed space within the mental health professions to provide such psychological care to those who seek it (cf. NARTH, 2012; Rosik, 2013).

Shidlo and Schroeder (2002) explicitly recruited former SOCE clients who felt harmed by their experience, with predictable findings. But at least they were willing to explicitly and emphatically emphasize their inability to generalize beyond their sample. Flentje and colleagues (2013), Dehlin and colleagues (2014), and Bradshaw and

colleagues (2014) have reincarnated Shidlo and Schroeder's methodology in a less overt manner through sampling that may appear more diverse but that functionally is quite similar in its effect. Moreover, the authors of these new studies are far more willing to draw conclusions and make recommendations that they have no assurance can actually be supported beyond their own study samples.

No doubt NARTH and other SOCE proponents would welcome this research were it utilized to offer guidance within the bounds of its limitations—such as the need for therapists to (1) provide SOCE within the ethical standards of their profession, (2) recognize the limitations of our current scientific understanding of sexual orientation change, and (3) offer up-to-date education on sexual orientation and SOCE to conservative religious communities. Sadly, the authors of the studies examined in this review have largely not chosen such a scientifically accurate and measured approach but rather offered what appear to be advocacy-emboldened recommendations that support the further professional marginalization and legal prohibition of professional SOCE. This only serves to fuel the polarization around SOCE that constitutes an ongoing disservice to individuals with unwanted same-sex attractions who seek professional psychological care.

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Possible Factors in the Development of Same-Sex Attraction (SSA)[1]

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[1] This paper is a revision of "Who Am I? Psychological Issues in Gender Identity and Same-Sex Attraction," pp. 70–98, in H. Watt (Ed.), *Fertility & Gender: Issues in Reproductive and Sexual Ethics* (Oxford: Anscombe Bioethics Centre, 2011). The original paper was based on a presentation given at the Linacre Centre for Healthcare Ethics—now Anscombe Bioethics Centre—International Conference on Fertility, Infertility and Gender in Maynooth, Ireland (June, 2010). A copy of this published paper along with the other conference proceedings may be obtained at http://bioethics.org.uk/index.php/.

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Abstract

Each human being, including one who experiences same-sex attraction (SSA), possesses a nature and existence that in some ways is universal, in some ways is pluralistic, and in some ways is unique. Genetic and biological factors may influence, but do not (pre-) determine, the development of gender identity in general or SSA in particular. Certain early life experiences influence the development of gender identity, depending on how these influences are perceived and internalized by the individual. Perceived disaffirmation from and other experiences with parents, siblings, peers, and/or others may predispose to, but do not predetermine, the development of SSA. Same-sex attractions have meaning beyond the simple desire for sexual gratification. These may include: 1) Unmet needs and unrealized growth and maturation; 2) unresolved feelings, unhealed hurts, and unreconciled relationships; 3) unrealistic hopes, fears, and expectations for self and others, and unfulfilling—and inauthentic—self-image/identity; and 4) unmanaged co-occurring compulsions and addictions (among them addiction to sex, alcohol and other drugs, and food) as well as disorders of mood (anxiety, depression) and personality. To be helpful, medical and mental health care for unwanted homosexuality—like all professional care for any presenting concern—must be given personally, one client at a time, to those who freely seek it.

Homosexual feelings and behavior are not innate or immutable, and homosexual behavior is not without significant risk to medical, psychological, and relational health. Understanding the psychological issues involved—including the risk factors and bio-psycho-social realities that those who experience unwanted SSA may face—may help such persons manage and resolve the issues involved as well as the unwanted SSA. Some state, national, and international legislatures and professional organizations are working to stifle, instead of to facilitate, the right of persons to receive—and professionals to give—assistance for dealing with unwanted SSA. Men, women, and children can hardly

be adequately described by a reductionist reference to their *sexual orientation*—in other words, their being *a* "heterosexual" or *a* "homosexual." Human beings have a much more fundamental identity.

Possible Factors in the Development of Same-Sex Attraction (SSA)

Introduction

On May 16, 2013, the Gallup Poll headlines read: "More Americans See Gay, Lesbian Orientation as Birth Factor—By 47% to 33%, Americans say it is inherent rather than product of environment" (Jones, 2013). A random sample of 1,535 adults was asked in a telephone interview: "In your view, is being gay or lesbian something a person is born with, (or) due to factors such as upbringing and environment?" According to the interview:

> Currently, 47% of Americans view being gay or lesbian as a sexual orientation (which) individuals are born with, while 33% instead believe it is due to external factors such as upbringing or environment. That 14-percentage-point gap in favor of "nature" over "nurture" is the largest Gallup has measured to date. As recently as two years ago (2011), the public was evenly divided. (Jones, 2013)

According to the graph accompanying the report, only 13% of respondents in 1978 viewed being gay or lesbian as "something a person is born with," while 56% viewed it as "due to upbringing/environment." This gap gradually narrowed until 2000/2001, after which the public has remained more or less evenly divided on this question for a decade—until now (Jones, 2013).

It is beyond the scope of this paper to discuss the factors that have led increasingly more people to believe that "being gay or lesbian" is due *more* to nature (something a person was born with) *than* nurture (external factors such as upbringing or environment). It is interesting to note, however, that the general public's views are not shared by the American Psychological Association (APA).

As early as 1998, the APA answered the question *What causes a person to have a particular sexual orientation?* as follows: "[M]any scientists share the view that sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors" (APA, 1998).[3] Ten years later, the APA took a similar position. In 2008, while acknowledging that research has studied "possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation," the APA concluded: "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. . . . Many think that nature and nurture both play complex roles" (APA, 2008). While the APA's views contradict the general public's growing belief that "being gay or lesbian [is] something a person is born with" (Jones, 2013), the APA unfortunately offers no evidence or suggestions to explain *how* sexual orientation *does* develop, either for specific persons or in general.

This paper reviews what a number of mental health professionals who have served clients with unwanted same-sex attraction (SSA), as well as what a few researchers and theorists, have observed about the possible causes of their clients' development of same-sex attractions, thoughts, and behavior, and how these professionals have interpreted these influences on their clients' experiences. The voices of these professionals are not the only ones that need to be heard, but they do offer invaluable insights about the experiences of some persons with SSA and

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[3] "How a particular sexual orientation develops in any individual is not well understood by scientists. Various theories have proposed differing sources for sexual orientation, including genetic or inborn hormonal factors and life experiences during early childhood. However, many scientists share the view that sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors" (APA, 1998).

guidance about the needs that some with SSA may have should they seek professional assistance.[4]

I. Each human being, including one who experiences same-sex attraction (SSA), possesses a nature and existence that in some ways is universal, in some ways is pluralistic, and in some ways is unique.

When discussing psychological issues that *may* be relevant for understanding gender identity development in persons who experience SSA, it is important to remember how unique each person is. I am mindful of learning more than 35years ago in a college undergraduate elective class in business management that "in some ways, all people are alike. In some ways, some people are alike. And in some ways, each person is unique." A similar idea was expressed recently in an interview given by biographer Joseph Pearce (2004):

> The paradox at the heart of every human life . . . is that we are both ordinary and extraordinary at one and the same time. We have so much in common with each other and yet we are all special, we are all unique. We are all of the genus homo, and yet we are all individuals.

Psychiatrist Jeffrey Satinover (1996) observes that "in reality, every person's 'road' to sexual expression is individual, however many common lengths it may share with those of others" (p. 221). Satinover emphasizes that even though many men

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[4] I have tried to offer a representative sampling of professionals whose work is fairly contemporary. The intent of the original presentation on which the original paper and this present paper are based was to offer a fair introduction, citing sources that were reasonably accessible to members of the audience, most of whom were not mental health professionals or researchers. I also tried to offer a sampling of observations about women, mindful that more is written about men who experience SSA by the male professionals who serve men than about women with SSA by the commonly female professionals who serve primarily or only women. I hope that readers find that the present paper does offer both ideas and sources of further information to those seeking either or both.

and women who develop SSA may share one or more characteristics or similar life experiences, none of these factors or experiences, either singly or in combination, themselves *determined* that the person would develop SSA.

Hallman (2008) offers a similar and profound overview of how many and varied factors interact in the lives of all women, leading some women to develop SSA, while other women with the same experiences do not. Hallman writes:

> All that is human, including sexuality, involves a mysterious weaving of our biological blueprint with our experiences, perceptions, cognitions, emotions, reactions and choices. Our genetically or biologically based qualities and traits . . . *directly [affect] how we perceive and process our worlds*. How we perceive and process our worlds in turn affects who we become. . . . All that is human, then, is extremely complex, categorically mysterious and potentially in flux. (pp. 51–52; emphasis in original)

Whether one is a professional engaged in the medical or mental health arts and sciences; a person engaged in public policy, legislative, or other political concerns; a pastor or active member of a religious denomination; or a private citizen, including a family member or friend, it is important to remember that each person is an individual—that he or she has his or her own story with experiences, responses, and choices that are unique to him or her. This includes those who experience SSA, as various mental health professionals who provide psychological care for unwanted SSA have reported. As psychologist Dean Byrd (2009) observes, "There are many differences among those who struggle with unwanted homosexuality" (p. 84).

Janelle Hallman (2009), a therapist who serves only women, remarks similarly:

> While these women often share common themes in their stories, similar strengths and, therefore, similar survival strategies, women with same-

> sex attractions and dependencies should never be stereotyped or squeezed into a 'box.' Like everyone else, they want to be known for who they truly are, apart from their sexuality or confusions or conflicts. Every woman who has or has had same-sex attractions is also wonderfully unique and special. They have various backgrounds, families of origin, experiences, personalities, character traits, relational styles, professions, appearances, marital status, developmental needs, abuse histories, religious upbringings, and talents and giftings. (p. 137–138)

Whether similar to or different from the stories of those who do *not* develop SSA, frustrations of certain longings for love and affirmation are commonly reported by those who do develop SSA. Yet, as Hallman (2008) writes, those who help persons attempt to resolve unwanted SSA find that no "*single factor individually determines or directly causes female SSA*" (p. 54, emphasis in original).

The same may be said for male SSA. Neil and Briar Whitehead (2013) reviewed more than 460 papers and books from the biological, psychological, sociological, and anthropological literature to try to understand what is and is not known about the causes of homosexuality, heterosexuality, and human behavior generally. The Whiteheads answer the question "What is the cause of SSA?" as follows: "There is no one cause. No single genetic, hormonal, social, or environmental factor is predominant. There are similar themes, childhood gender nonconformity, sexual abuse, peer and family dynamics, sexual history, but the mix varies with individuals making individualistic responses the single overriding factor" (pp. 271–272). A given person who experiences gender nonconformity, sexual abuse, particular peer and family dynamics, a certain sexual history, and/or other factors *may* develop SSA, but many persons with the same experiences or factors in their lives will not.

II. Genetic and biological factors may influence, but do not (pre-) determine, the development of gender identity in general or SSA in particular.

While there is no one-size-fits-all developmental blueprint for the origins of SSA, this and the following sections describe a number of factors commonly observed by clinicians and researchers, as well as reported by persons with SSA concerning their unique and common developmental experiences. Neil and Briar Whitehead (2013) explain that whatever may influence *any* and *all* of our human behaviors, including SSA, "genes don't make you do it. There is no genetic determinism, and genetic influence at most is minor. Individualistic reactions to random factors are very important. . . . The fact is that nothing *makes* us do anything—neither our genes nor our environment" (pp. 270, 271; emphasis in original).

While those who promote the normalization of SSA may publicly argue that people are "born that way," there clearly is no scientific evidence to support the view that SSA is genetically or biologically predetermined. The few studies that have been misreported in the media as offering support for such predetermination either have been discredited or were not supported in subsequent, higher-quality research (Whitehead & Whitehead, 2013 pp. 128–139, 150–157, 168–172, 174–206). As discussed above, the APA (1998, 2008) also concludes that SSA is *not* genetically or biologically predetermined.

Although genetic and biological factors do not predetermine the development of gender identity and/or SSA, they *may* be relevant. For example, Patton (2009) lists the following common personality traits observed among women who seek therapy for unwanted SSA: "Above average intelligence, strong sensitivity, creativity, analytic ability, curiosity, a strong sense of justice, and natural abilities and interests outside of stereotypical female interests and talents, such as being active or athletic" (p. 99; cf. Hallman, 2008, pp. 54–55).

Both similarly and conversely, Nicolosi (2009a) notes that "among SSA men we often see a temperament that is sensitive, emotional, relational and more aesthetically

oriented than the gender-typical male" (p. 36). Nicolosi explains further that while such sensitivity, abilities, and interests are great gifts, such attributes also leave boys more vulnerable to being and feeling hurt emotionally. In response to distressing, isolating experiences in their families and among peers, such gifts may lead some boys to avoid interaction with other persons and to seek relief through fantasy or impersonal relationships in which they may feel safe(r) and over which they experience (more) control.

Similarities, differences, and complementarities in temperament between a child and his or her own parents as an infant and toddler, and with siblings and peers as the child grows, may *predispose* to but do *not predetermine* the later development of SSA. Being and/or perceiving and feeling oneself as too "different" from one's same-sex parent, siblings, and/or peers—and likewise too similar to, or vulnerable to being harmed by, those of the opposite sex—may predispose to the development of gender insecurity or gender inferiority, which in turn may predispose to SSA.

Pediatrician Michelle Cretella, MD (2012), offers an interesting perspective on the development of SSA:

> It is a well-accepted scientific fact that complex behavior traits regularly involve the interaction of multiple genes with multiple environmental factors, plus *free-will choices*. Why would SSA and its associated behaviors be different? In fact they are not. That is why it is accurate to say both that sexual attractions are generally not chosen, but that responses to those attractions do involve choice. Unbidden attractions may come because of situational factors and prior sexual experiences. There may be a biological predisposition that makes such attractions more likely than not. However, these attractions may be increased or decreased by the choices that people make. The medical term for this

dynamic is a "biopsychosocial model mediated by choice." (p. 132; cf. Abbott & Byrd, 2009, pp. 35–46)

III. Certain early life experiences influence the development of gender identity, depending on how these influences are perceived and internalized.

Experiences throughout one's life influence the development and maintenance of a person's gender identity.[5] Especially in one's infancy and early childhood, one's gender and identity is both "caught" and "taught," as a result of how one perceives others living as gendered beings; how one is related to by others as a gendered being; how "good"

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[5] This section is the fruit of a myriad of experiences—personal, clinical, and professional—as well as professional and scientific study. That all facets of our experience as human beings—including psychosexual, socioemotional, cognitive, and biological—may and commonly do develop over the course of a person's lifespan is a mainstream understanding of the social and behavioral sciences (Santrock, 2012). Clinical approaches emphasizing brain "neuroplasticity," i.e., the ability of the brain itself to change over the lifespan, and specifically each person's potential for engendering such change—with and/or without professional assistance—in order to influence how one behaves, likewise is a commonly accepted position in contemporary medical and mental health practice (Doidge, 2007; Schwartz & Begley, 2003; Schwartz & Gladding, 2011).That changing one's behavior and thoughts—including one's gender identity—and the brain biology that facilitates or inhibits how one aspires to live is *possible,* even for gender identity, does not mean either that it is advisable that a given person try to change, nor to what extent a given person's efforts may be successful in changing how she or he may think or act at a given time. While this paper mentions "gender identity" because this is a dimension of every human being's life, including those who experience SSA, there is neither the time nor space for even a brief overview of clinical issues such as gender identity disorder, gender dysphoria, and transgenderism. That said, it is worth noting that the APA (2011) answers the question "Why are some people transgender?" as follows: "There is no single explanation for why some people are transgender. The diversity of transgender expression and experiences argues against any simple or unitary explanation. Many experts believe that biological factors such as genetic influences and prenatal hormone levels, early experiences, and *experiences later in adolescence or adulthood may all contribute to the development of transgender identities.* (p. 2; emphasis added) This answer sounds remarkably similar to how the APA (1998, 2008) answers the question "What causes a person to have a particular sexual orientation?" that is mentioned in the introduction. Implicitly, the APA asserts that "gender identity," like "sexual orientation," is *not* simply an innate, biological "given."

one evaluates living, now and in the future, as one's biological sex; and how thoroughly one internalizes and externalizes these "lessons" in one's interactions first within and eventually outside of one's family.

Personal and sexual identity is the result of both "seeing and hearing"—in other words, experiencing, often outside of conscious awareness, the "answers" to a number of questions. These include:

Who am *I*? Is it good that I exist, that I am?

What is a boy or a girl?

Am *I* a boy or a girl? Is that good?

Am *I* good enough as I am?

How do boys/girls act? How am *I* supposed to act?

How well (good) do *I* act as a boy/girl?

How does Mom treat Dad, and other boys or men—including my brothers? Compared with *me*? Is it good?

What does that say about me and *my* goodness, especially as a "boy" or "girl"?

How does Dad treat Mom, other girls or women—including his mother? His and my sisters? Compared with *me*? Is it good?

What does that say about *me* and *my* goodness, especially as a "girl" or "boy"?

In early childhood and throughout one's transition to adulthood, one begins to more formally ask, or at least enact, implicitly answered questions about living as an adult:

What does it mean to be a male or a female person, a man or a woman?

What do men/women do? How do they act? How am *I* supposed to act when I grow up? What is *my* gender identity?

Given that identity: How may—and must—any man or woman live so as to flourish?

How may—and will—*I* live well as the man—or woman—that *I* am?

Answers to such questions profoundly influence one's ability to flourish as the boy or girl, and later as the man or woman, the male or female person, that one is intrinsically and becomes over time.

IV. Perceived lack of or disaffirmation from and other experiences with parents, siblings, peers, and/or others *may predispose* to, but *do not predetermine*, the development of SSA.

In words that in large part also describe the phenomena of male homosexuality, Hallman (2008) explains the "extremely complex, categorically mysterious and potentially in flux" nature of female SSA[6] as follows:

> [F]emale homosexuality is a multidimensional infrastructure, intricately linked to a woman's biology, experiences, cognitions, emotionality, relational networks, concept of self and inherent design as a female made for relationship and meaning. In light of this complexity, . . . female SSA cannot be explained by a single clinical picture with common underlying dynamics. (p. 52)

In spite of there being no "single clinical picture with common underlying dynamics" for explaining female—or male—SSA, there nonetheless are common

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[6] The "flux" of SSA is to some degree general for all persons and to another degree more common among women. On the one hand, as the APA (2009) concludes, "Recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid" (p. 14). On the other, the APA also mentions the particular "experiences of fluidity and variation in sexuality and relationships" among women (p. 63). Diamond (2008) has written extensively about the fluidity, flux, or changeability—unassisted by professional or other efforts—of female sexuality and SSA.

dynamics worth considering. For example, whether one is a male or female child, one enters life needing to be loved. Reflecting on the women with unwanted SSA whom she has served, Hallman (2009) remarks: "They were little girls at one point. They innocently looked up into the eyes of their mother and father longing for love, comfort, attention, hugs, patience and understanding. Many of their stories are not so different than many of ours" (p. 138).

Certain life experiences, including particular intra- as well as interpersonal influences and environments, commonly *are* associated with (in other words, appear to contribute to) the development of SSA in some persons. While many risk factors may be common among persons who experience SSA, typically many more persons with the same attributes and/or experiences do *not* develop them (Whitehead & Whitehead, 2013 pp. 16, 26, 270–271, and Chapters 10 and 11). Nevertheless, a *risk factor model* is helpful for understanding the development of SSA. Such a model recognizes that certain experiences *may predispose* a person to develop a particular way of thinking, feeling, or behaving, but *do not (pre-) determine* this development or compel a person to think, feel, or act in this way.

Some of the risk factor experiences associated with SSA may occur early in life, indeed even during infancy and toddler-hood. Common risk factors associated with the development of SSA feelings and behaviors include: 1) Gender atypical characteristics: temperament, abilities, interests, and/or physical appearance. 2) Gender incongruity or distortion associated with disruptions in one's intrapersonal (i.e., internal) experience of masculinity or femininity. 3) Same-sex disaffiliation associated with disruptions in interpersonal experience with older members and/or peers of one's own sex, especially parents, siblings, and classmates. 4) Opposite-sex relational wounds associated with older members and/or peers of the opposite sex, including parents, siblings, friends, and classmates. 5) Sexual abuse from members of the same or opposite sex. 6) Habits of

gratification, which—especially if they represent ways of compensating for intolerable, recurrent feelings—may become compulsions or addictions.

While each person who experiences SSA is unique, common *themes* or *issues* have been found in the life experiences of many who develop SSA. For example, Byrd (2009) explains that "along with one's biological 'givens,' non-conforming children are vulnerable to a number of difficulties, including those associated with homosexuality" (p. 60). Byrd reports further:

> Dean Hamer, the self-identified gay researcher [who was touted incorrectly by the popular press as having found 'the gay gene'], noted that *gender nonconformity* is the single most common observable factor associated with homosexuality and concluded that "In fact, it may be the most consistent, well-documented, and significant finding in the entire field of sexual orientation research and perhaps in all human psychology" (Hamer & Copeland, 1994, p. 166). (p. 60; emphasis added)

From childhood through adolescence, perceived and actual difficulties with having one's gender and gender identity affirmed by one's family and peers may leave a young person vulnerable for developing SSA. As psychologist Maria Valdes (1996) writes:

> In homosexuality there is a *disidentification with self*, with the person one is. The person is body and soul at once with a specific physiological sex, either male or female. If the gender (identity) is not developed and integrated with the physical sex, a basic unmet need is established in the individual for which he is not responsible at all. This *need for gender identity* will remain until it is met. (p. 363; emphasis added)

Mettler and van den Aardweg (2010) conclude similarly that

> upon examining the psychological and psychiatric observations and research evidence of recent decades, there is a steadily growing consensus that same-sex attractions somehow spring from *failed "gender identification"* ("gender nonconformity" and the like) during childhood and adolescence, due to imbalanced parent-child interactions and peer-group maladaptation. (p. 5; emphasis added)

Same-sex attractions are understood as arising from "feelings of inadequacy with respect to one's gender identity." In effect, SSA involves "compensatory reactions to inferiority feelings with respect to one's masculinity or femininity" (p. 5).

Reflecting on his experience of serving hundreds of men with unwanted SSA, Nicolosi (2009a) likewise observes that certain patterns of experience are common among his clients. He describes two basic patterns: 1) *pregender* and 2) *postgender* homosexuality (pp. 81–85). Using the constructs of psychodynamic theory, *pregender* SSA involves "a failure to negotiate the gender-identity acquisition phase of one-and-a-half to three years old" (p. 82). When this phase is negotiated successfully, a boy disidentifies with his mother and identifies securely with his father. When this effort is unsuccessful, several experiences are commonly observed. A boy may have experienced insufficient maternal nurturing, which leads to his being poorly attached to the mother. "Insecure attachment" commonly is associated with the development of a "self-deficit"—in other words, a lack of a clear sense of self. Such effects are magnified should there also be "a failure to bond with the father." A boy's inability to perceive and experience his father as "salient and benevolent" commonly leads to a "gender-identity deficit" (p. 81).

By contrast, a man who experiences the *postgender* type of SSA commonly has "successfully completed the gender identity phase (of male human development) but later experienced another form of trauma for which homoerotic desire became conditioned as an affect regulator" (p. 82). Rather than desiring the attention and qualities of an "idealized masculine type" of man, a person with postgender SSA commonly "looks for masculine affirmation"—in other words, for "the anxiety-reducing reassurance of male support and comfort against his inner insecurity." Possible sources of the trauma contributing to such masculine insecurity include "an abusive older brother; cruel, teasing peers at school; a disorganizing, destabilizing mother," along with a father who may have been experienced as too "weak or ineffectual" to defend the boy against such repeated traumas (p. 83). Nicolosi notes that a postgender-type client often may have "distinct sexual attractions to women but little or no interest in female friendship" (p. 83).

In a chapter entitled "Putting the Pieces Together," Jeffrey Satinover (1996) describes "just one of the developmental pathways that can lead to homosexuality, though a common one" (p. 221). This pathway shares many features with those described above by Byrd (2009), Mettler and van den Aardweg (2010), Nicolosi (2009a, 2009b), and Valdes (1996).

Although the preceding explanations are the results of clinical experiences serving primarily male clients seeking to resolve unwanted SSA, similar observations may be made about women. As mentioned above, Hallman (2008) emphasizes that no single clinical picture or set of underlying dynamics adequately explains why a given woman may develop SSA. But Hallman has also observed and described some life events, traits, and characteristics that women who experience SSA may share.

For example, while realizing that each woman she meets is "wonderfully unique and special," Hallman has noted that many—but not all—women who experience SSA have experienced "interferences, stressors or failures in their most

primal attachment"—their mothers. Such "perceived or actual disruptions" of bonding may have occurred in the context of "prenatal, birth and postnatal complications"; "accidental or uncontrollable separations from their mother" due to a variety of circumstances; "maternal deficits or weaknesses" stemming from their mothers' own personal histories; and, at times, "actual maternal abuse or abandonment" (pp. 57–58; cf. Hallman, 2008, pp. 58–65). For some clients, "the shock of puberty" and the often corresponding experience of a "disparaging self and body image" are distressing factors associated the development of SSA (pp. 90–93).

Many women with SSA have lacked an engaged and affirming father and/or grew up in a family with gender roles or other relational dynamics that were dysfunctional (pp. 67–72). Other factors such as sexual abuse (pp. 82–85), disappointing or negative experiences with boys or young men (pp. 92–93), too few childhood girlfriends (pp. 85–87), and/or a particularly satisfying relationship with a young woman in adolescence or young adulthood (pp. 93–96) may have contributed uniquely to a woman's development of SSA. Of course, even when such experiences do not lead to a woman developing SSA, she is likely to experience other *intra*- and *inter*personal difficulties.

Hallman (2008) also has recognized "certain diagnostic and behavioral or personality patterns among women with SSA." This experience has led her to describe four common "profiles" that guide how she serves each woman. These profiles include the following: 1) Empty, depressed, withdrawn, and isolated. 2) Tough, angry, sarcastic, and barricaded. 3) Energetic, caretaking, drama-oriented, and never "home." 4) Pragmatic, perfectionistic, distant, and smugly self-assured (cf. pp. 158–180). Hallman emphasizes that the terms associated with each profile are intended to identify common "characteristics or traits that have most likely emerged out of a woman's unique survival modes and defenses [self-defeating habits of self-protection], compensations or false selves." While such characteristics "may highlight" some of a woman's "true strengths

and authentic inner conflict[s] . . . they are *not* descriptive of a woman's truest and fullest God-given self" (p. 159).

Hallman explains further that while such profiles enable the therapist to understand and establish "appropriate treatment guidelines and goals . . . they are primarily descriptive in nature. . . . [I]ndeed, many women *may* identify with one profile or another, but will most likely see parts of themselves in each of the other profiles as well" (p. 159). Hallman views these profiles as overlapping and "perhaps better understood as various *personas* within each individual woman based on her salient needs and the therapeutic themes experienced at different stages of her process." It is likely that the identified needs and suggested treatment approaches for each of the profiles "will benefit every woman in due time" (p. 159). Hallman reports that she is cautious about sharing such therapy-guiding profiles with clients, lest they experience confusion or a sense of being judged or unhelpfully *labeled*.

Women—and also men—with unwanted SSA who are public about practicing their religious faith and who accept the teaching that homosexual behavior is inconsistent with moral maturity and human flourishing may experience additional difficulties. As Hallman (2009) writes:

> Faith-based women struggling with same-sex attraction face some unique issues, such as *profound shame*, *sense of condemnation*, *fear of sharing* about their struggle with others, *finding more support from the gay community* than their church, and possibly a long string of *relational breakups*. (p. 139; emphases added)

Some may suffer from "condemnation" by fellow church-goers—or their own parents or other family members—based on misunderstanding of the genesis or nature of SSA (for example, the belief that people choose to develop SSA or that "feeling" SSA

in itself is sinful). Others may suffer from a "misguided mercy" within the church—or their family—that accepts, perhaps even condones or celebrates, the practice of behaviors that place the persons who practice them at significant risk for physical, psychological, relational, and spiritual harm (see Section VII below) .[7]

V. Same-sex attractions may and often have meaning beyond the simple desire for sexual gratification.

This section includes my integration and summary of what a number of therapists and a few researchers have observed and theorized about two things: first, which factors are correlated with and may have contributed to a given client's or many clients' experience of unwanted SSA, and second, which core or additional issues the client

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[7] A discussion of the spiritual and religious needs of persons with SSA is beyond the scope of this paper. Such needs are recognized and efforts to meet them are strongly encouraged. The spiritual and religious needs of the clients of licensed mental health professionals in general have been the focus of much research and clinical practice (Richards & Bergin, 2000; 2004; 2005). Also, Principle E: Respect for People's Rights and Dignity of the APA (2010) Ethical Principles of Psychologists and Code of Conduct clearly advises psychologists to "respect the dignity and worth of *all* people" and to be "aware of and respect cultural, individual, and role differences, including those based on . . . *religion*" (p. 2; emphasis added). The *APA Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation* (2009) likewise repeatedly asserts that religious beliefs in regard to homosexuality must be respected (cf. pp. 5, 19–20, 51, 53, 56, 59, 64, 69, 70, 77–78, 82, 120).

There also have been efforts to understand the wise use of scientific research and clinical experience in discussions about how religious practice and pastoral care may serve the needs of believers who also experience SSA (Jones & Yarhouse, 2000), as well as research documenting that some persons are better able to manage and resolve unwanted SSA through religious and spiritual resources and activities (Jones & Yarhouse, 2007, 2011; Phelan, Whitehead & Sutton, 2009). Guideline 3 of the NARTH (2010) "Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior" encourages *all* clinicians "to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing change-oriented interventions" (p. 18). Hopefully, persons whose deeply held religious values motivate them to seek professional assistance to deal with unwanted same-sex attractions will find professionals both willing and able to help them.

may want help with when seeking help to deal with, manage, or resolve unwanted SSA. For example, a client who seeks professional help to stop smoking probably needs help learning how to relax in healthier ways. In this case, his or her urge to smoke may mean a need to relax and an inability to do so. Similarly, clients who experience unwanted SSA may need to deal with one or more other factors. The therapist and client both need to understand what the SSA means in order for timely assistance to be offered and received.

My review of the clinical and scientific literature, along with my own clinical experience, suggests that a client reporting unwanted SSA may need to work on further growth in his or her intrapersonal and interpersonal development. This "un"-done work may include dealing with unrealized growth and maturation, unmet needs, unhealed hurts, unresolved feelings, unreconciled relationships, unclear boundaries, unrealistic hopes, fears and expectations (for self and others), an unfulfilling and inauthentic self-image or self-identity, and unmanaged co-occurring (i.e., comorbid) difficulties. In some, these factors and issues may overlap; in others, they may not be relevant.

At times, unmet developmental needs and unfortunate experiences with members of one's family of origin and/or peers may leave someone with unprocessed feelings, the need for grieving, and the challenges of growing up. Other times, a person may have worked through them on his or her own. Also, behaviors and habits of homosexual gratification, as well as many co-occurring difficulties and disorders, may be preexisting, coexisting with, and/or consequential to the development of SSA. For some persons, these co-occurring difficulties may have developed as ways of attempting to compensate or substitute for, numb, or otherwise deal with other underlying issues, including SSA and the factors contributing to its development.

I have summarized below a list of possible meanings—in other words, undone work—under five categories. To illustrate and validate some of the undone work that SSA may indicate, I offer observations and interpretations from a number of mental health professionals who have served persons with unwanted SSA. As explained above,

while the following statements may represent the life stories or challenges of some—and perhaps even many—persons who experience unwanted SSA, the statements may not apply to a given individual. It's important to realize that each person has his or her own unique story and immediate life circumstances and challenges.

• ***Unmet needs and unrealized growth and maturation***. Therapists who serve persons with unwanted SSA commonly find that their clients may have had developmental needs that for one or more reasons were *not* fulfilled. As a consequence, such persons may have failed to grow and mature in ways that persons whose needs were met commonly grow and mature. Commenting on her experience of persons in general, psychologist Maria Valdes (1996) observes:

> Every child has certain basic needs that have to be met so that he (or she) is able to attain full psychological development; psychosexual development is included. Some of those needs are *affection, individuation, autonomy, independence, acceptance,* and *gender identification with one's own physiological makeup.* (p. 347; emphases added)

Commenting on her experience with persons with SSA, Valdes (1996) considers that a "person with a homosexual condition is one with an *incomplete or arrested psychosexual development* that manifests itself by the need of that person to stay at a homopsychosexual stage of development rather than to complete the psychosexual cycle and become heterosexually oriented" (p. 346; emphasis added). Valdes describes "psychosexual development" as including "attitudes and ways of perceiving and relating to others, in other words, a kind of mind set that is more than sexual" (pp. 346–347).

A commonly unmet need shared by many who experience SSA is the need to experience—again or perhaps for the first time—genuine *affirmation*, or unconditional love:

having another recognize one's intrinsic worth and having the other attend to and serve one's ultimate, authentic well-being. Related needs include growing in genuinely, mutually affirming same- and/or opposite-sex relationships, which enables the development of appropriate and timely same- and opposite-sex attachment/affiliation, as well as opposite-sex (dis-) identification. Meeting such needs ultimately allows persons to flourish or thrive in their innate masculinity (if a boy or man) or femininity (if a girl or woman).

The work of psychiatrists Conrad Baars and Anna Terruwe (Baars, 2008b; Baars & Terruwe, 2002) on helping people understand and satisfy their universal human need for affirmation—and resolve the effects of its absence—offers insight for understanding the meaning of SSA. All human beings have the need to be "adequately affirmed during their developmental years by unselfishly loving, affectionate, mature parents and/or other significant persons" (Baars, 2008b, p. 190).

The experience of being un- or underaffirmed commonly leads to difficulties with the mature expression of sexuality, whether one's objects of attraction are heterosexual or homosexual. Baars (2008b) explains that *all*

> unaffirmed persons have one concern and need: to become affirmed, to be loved for *who they are* and not for *what they do*. They are literally driven to find someone who truly, unequivocally loves them. . . . If affirmation by a significant other is not forthcoming, many unaffirmed persons will use their talents, intelligence and energy to try to convince themselves and the world in a variety of ways that they *are* worthwhile, important, and significant, even though they don't feel that they are. The most common ways of doing this are by the acquisition, display and use of material goods, wealth, power, fame, honor, status symbols, or sex. (p. 191; emphasis in original)

Concerning the development of SSA in particular, Baars (2008b) comments: "[A]ny of the factors which in very early life cause the innate predisposition to a heterosexual orientation to change to a homosexual one are at the same time detractors from or obstacles to full affirmation" (Baars, 2008b, p. 189). Nicolosi (2009b) offers a similar observation that a lack of same-sex *affirmation*—which he calls *attention, affection, and approval*—contributes to the development of SSA. Writing about men, Nicolosi states: "I see homosexual attraction and behavior as an attempt at 'reparation' [or compensation] . . . attempting to "repair" normal, unmet same-sex affective needs for 'attention, affection and approval,' as well as gender-identity deficits through an erotic connection with another man" (pp. 32–33).

Janelle Hallman (2009) has observed that female clients wishing to manage and resolve unwanted SSA experience similar, complementary needs. Hallman writes that women commonly need to grow in authentic, emotional, and relational *interdependence*. "At the heart of most female same-sex relationships is *an extremely deep emotional bond* [emphasis added] . . . often more restrictive than fulfilling to each individual woman . . . referred to as fusion, merger and *emotional dependence"* [emphasis added] (p. 149). Hallman observes that when two women are engaged in such an emotionally dependent relationship, "[W]hen the pressure of relational need achieves maximum intensity, while at the same moment, a new woman comes along who is compassionate and empathetic or has other qualities worthy of admiration . . . a response of *emotional overattachment* [may be] triggered" [emphasis added] (p. 149).

Other therapists have complementary perspectives on both male and female SSA, having noted their clients report many unmet needs and also exhibit relational immaturity in same- and opposite-sex relationships. For example, Dean Byrd (2009) observes that homosexuality commonly develops as a response to the lack of—and is resolved through the engendering of—mature, same-sex relationships. He explains:

> Essentially, homosexuality is interpersonal both in its genesis and in its resolution. The attainment of healthy, non-sexual, same-sex relationships is a prerequisite to . . . begin the heterosexual journey toward wholeness . . . to the development of heterosexual attractions and subsequent heterosexual relationships . . . allowing gender complementarity to emerge and be nurtured and sustained. (pp. 85–86)

Mettler and van den Aardweg (2010) view SSA as a search for the masculinity that a man perceives he lacks or the femininity a woman perceives she lacks—and the attempt to obtain or fulfill these qualities by relating to another person of the same sex who seems to have what one lacks. Mettler and van den Aardweg observe: "Homosexual desire is an obsessive quest for masculinity, for belonging to manhood (in the case of the lesbian woman, for femininity, for belonging to womanhood) and for male (or female) affection, to compensate for inferiority feelings regarding one's own gender" (p. 5).

As men and women experiencing SSA begin to understand, manage, and resolve both the experiences of having such basic needs unmet and their learned intra- and interpersonal habits for responding to these experiences, psychosexual maturing and flourishing may occur. For example, Hallman (2009) describes the process by which a woman who receives adequate personalized support may come to address "her *authentic dependency and attachment needs* [emphasis added] . . . also . . . to progress through the stages of forming and solidifying a *sense of self*" [emphasis added] (p. 150). Hallman explains that addressing such needs with a supportive therapist may enable the woman to "to challenge [her] core beliefs such as the assumption [that] she cannot exist without a special friend." Therapy may enable a woman "to learn about and evaluate her relational boundaries," which includes helping her to "work on objectively naming and separating her emotional state from that of her friend." This process commonly involves supporting a woman as she learns how to "negotiate her own emotions and distinguish between what

she feels and what her friend is feeling" in order "to experience her own set of emotions [and life] apart from what her friend is feeling or experiencing" (p. 150).

Writing about men as well as women, Baars (2008b) explains that when human beings have been "adequately affirmed during their developmental years"—or even *belatedly* during their adult years—they have "received the gift of themselves" that enables them to "feel worthwhile, significant, and loveable," as they are, unconditionally. Such persons grow and mature into knowing "who they are."

> They are certain of their identity. They love themselves unselfishly. They are open to all that is good and find joy in the same. . . . They find joy in being and doing for others. They find joy in their loving relationship with their Creator. They can share and give of themselves, be a true friend to others, and feel at ease with persons of both sexes. (Baars, 2008b, p. 190)

Valdes (1996) observes further that when a person who experiences SSA (the "homosexual condition") due to "incomplete or arrested psychosexual development" (p. 346), he or she may strive to complete or mature in his or her psychosexual development. Valdes comments further that if such a person "attains heterosexuality, [her or his] homosexuality has not been reversed; rather, [his or her] psychosexual development has been completed" (p. 347). (The observation that change in SSA is best considered on a continuum—meaning that *some* but *not all* clients may experience such completeness of their "psychosexual development"—is discussed below in Section VII.)

• ***Unresolved feelings, unhealed hurts, and unreconciled relationships.*** Clients who seek professional assistance for unwanted SSA commonly report a number of concerns, including distressing emotions and other feelings, such as anxiety, depression, anger, sadness, sorrow, and shame, and the pain of rejection, abandonment, or not being good enough. Such feelings may be the result of past and/or present experiences of actual

and/or perceived rejection by—or estrangement from—parents, other adults, siblings, peers, and past or present love objects. Consequences from unfortunate experiences in such relationships are discussed above in Section IV.

Psychologist Gerard van den Aardweg (2011) summarizes a review of the clinical literature, in light of his experience of serving many clients, as follows:

> [M]any studies have shown that the most significant factor which correlates with homosexuality is "gender nonconformity" or *same-sex peer isolation* [emphasis added]. Another factor closely associated with homosexuality is an *imbalance in parent-child interaction* [emphasis added], notably forms of over-influence of the opposite-sex parent in combination with a deficient relationship with the same-sex parent. (Abstract, p. 330)

Relevant to van den Aardweg's observation about persons with SSA often experiencing an *imbalance in parent-child interaction,* psychiatrist Richard Fitzgibbons (1999) offers the following observations about the painful emotions that are commonly experienced and left unresolved in such situations:

> [When there is] a lack of involvement by the father in the life of a son [who develops SSA] . . . a common pattern of reaction to *emotional pain* can be observed and identified. When a person is hurt in a relationship . . . first *sadness* develops, then *anger* accompanied by *low self-esteem*, and finally a *loss of trust*. It is essential to resolve the *anger* associated with all these types of *betrayal pain*. . . . The approach that seems to be successful is to help the client face the *pain*, resolve the *betrayal anger* by working at understanding and forgiving his father and be healed of the *craving for father love*. (p. 91; emphasis added)

As significant a factor a disaffirming relationship with one's father can be for boys, both Fitzgibbons and van den Aardweg consider disaffirming experiences with same-sex peers as potentially even more important for a boy. Fitzgibbons (1999) states that in his clinical experience, more important than a man having had a "poor emotional relationship with [his] father" is the "weak masculine identity" resulting from "severe peer rejection." Such rejection commonly is associated by a "sports wound"—in other words, an inability to play sports well enough to feel accepted by his male peers—that "will negatively affect the boy's image of himself, his relationships with his peers, his gender identity and his body image" (p. 88).

Van den Aardweg (1997) also emphasizes the importance of experiences and relationships with peers in the development of "the homosexual wish," or SSA. Van den Aardweg observes that SSA is rooted in "unconscious self-pity and *feelings of gender inferiority.*" Under the influence of "his *masculinity/femininity inferiority complex* or *gender inferiority complex*," a man with SSA "partly remains a 'child', a 'teenager'." As significant as "specific parental attitudes and parent-child relationships may" be in predisposing a young man to develop "a homosexual gender inferiority complex, . . . the *lack of same-sex group adaptation* weighs even more heavily as a predisposing factor." Van den Aardweg asserts that more than "the great importance of child-parent interactions, the final determining factor generally lies more, however, in the adolescent's self-image in terms of gender, *as compared with same-sex peers*" (pp. 19–20; emphasis in original).

As mentioned above in Section IV, Hallman (2009) notes that women may develop SSA as a consequence of distressing experiences with parents, peers, or others. These may include various difficulties: in the attachment process with their mothers; in their developmental relationship with their fathers; with various family dynamics; in experiences with peers; and as a result of painful or overinvolved—if not abusive or otherwise traumatic—experiences with intended or actual girlfriends, with boys

or young men, and/or with other adults. Hallman further explains that a survival and coping mechanism—for men as well as women—is *defensive detachment* and *same-sex disidentification* (p. 65).

Hallman notes that defensive detachment was first described as such by Elizabeth Moberly (1983) as "not only childhood withdrawal or childhood withdrawal or disinclination to emotionally connect with the same-sex parent, but also the decisive refusal to *ever* reconnect" (Hallman, 2009, p. 65; emphasis in original). Nicolosi (2009a) likewise observes in males with SSA the development of what Moberly called "defensive detachment" as well as self-protective "dissociation," often leading to passive-aggressive nonassertion and the experience of "shame" (pp. 78–79).[8]

With wisdom suitable also for a man, Hallman (2009) advises the woman who is dealing with unwanted SSA—or any *intra*- or *inter*personal responses to unfortunate relationship experiences—to "expect and prepare for *grief* and *depression*" [emphasis added] (p. 150). In order to let go and discover "God's design for healthy intimacy," a woman—or man—with SSA must learn to cultivate "multiple relationships with healthy limits that are free and generous with ample give and take" (Hallman, 2009). Doing so

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[8] A metaphor that I use in sessions with clients, working on a variety of issues, may be helpful. Clients and I often talk about their *emotional sunburn*—leftover feelings from past situations that are commonly aggravated in the present. This may be as simple as having had a bad day and then overreacting to someone who did something we found disappointing or annoying. In such a case, one may unload or displace preexisting sadness or frustration along with any new feelings onto the person who is the occasion of one's disappointment or annoyance in real time. Perhaps that person was also the occasion of some or much of one's emotional leftovers. Sometimes people learn to respond to their emotional sunburns by avoiding people, places, and things that may (re-)aggravate or engender the unwanted feelings. Defensive detachment, discussed above, may be a way of avoiding, distancing oneself emotionally from, or relating only superficially with a particular person—parent, sibling, etc.—or group of people (such as all men or women) in order to protect from (re-)feeling their emotional sunburn. Other habits—such as sexual gratification, substance abuse, or eating disorders—likewise may enable a person to ease the discomfort of his or her emotional sunburn. Sometimes such easing may occur without a person being consciously aware that the discomfort is there.

commonly requires that a person allow himself or herself to become aware of and feel the anger—and the sadness, pain, and perhaps fear that commonly underlie this anger—that is left over from earlier unfortunate experiences.

Similarly, writing about men but with wisdom relevant for women, Fitzgibbons (1999) explains that, "It is essential to resolve the *anger* associated with all these types of *betrayal pain*. . . . The approach that seems to be successful is to help the client face the *pain*, resolve the *betrayal anger* by working at understanding and forgiving his father and be healed of the *craving for father love*" (p. 91; emphasis added). Nicolosi (2009a) likewise discusses the need for "grief work" that enables a man to (re-)discover his previously repressed and suppressed emotions and (re-)experience the emotional vitality necessary for assertive living.

In general, persons with SSA—and/or other difficulties—may need to do the often uncomfortable work of resolving persisting anger toward offending *significant others*—whether parental, peer, partner, and/or other—through assertive self-care, grief work, forgiveness, and perhaps reconciliation, if the latter is possible and wise (Baars, 2008a; Enright, 2001, 2012; Enright & Fitzbibbons, 2000). For as Baars (2008b) summarizes, "In the therapy of homosexual and heterosexual unaffirmed persons, the vicious circle of *feeling unloved—seeking/buying love—being frustrated—and feeling more unloved* is broken" (p. 195), not uncommonly through resolving repressed (unfelt, unconscious) self-protective anger.

• Unrealistic hopes, fears and expectations for self and others, and unfulfilling—and inauthentic—self-image/identity. Therapists commonly find that clients who experience unwanted SSA expect themselves and/or others to be perfect or ideal. Conversely, clients often live with the belief that they are worthless—or at least not good enough. Many may perceive others as having the ideal qualities that they themselves lack or being the ideal persons they believe they themselves need to be. Such unrealistic expectations for self and others may lead persons with SSA to relate to others

in a self-defeating cycle: *idolizing/idealizing* others, then *demonizing* them when they fail to meet expectations. Persons with SSA, although initially attracted to someone, nonetheless may in their emotional hearts truly expect the worst—rejection—and act in ways that contribute to the very rejection they fear. Persons with SSA also may come to identify themselves with their sexual feelings, as if *having* SSA determines their *being*—their essence or nature, *who* or *what* they *are*—instead of SSA expressing merely *how* they may happen to feel, think, or act at a given time.

Van den Aardweg (1997) makes some sobering reflections about the nature and consequences of the self-identification reported by many persons with SSA. He views self-identifying according to how one feels or acts or to the lifestyle one is living as a risky, self-defeating venture. He asserts that it is a "psychologically dangerous *decision* to identify oneself as a different species of man: 'I *am* a homosexual.'. . . It may give a sense of relief after a period of struggle and worry, but at the same time it is defeatist" (p. 23; emphasis in original).

According to van den Aardweg, "The self-identified homosexual takes on the [*tragic*] role of the definitive outsider. . . . That role brings certain rewards. . . . It makes one feel at home among fellow homosexuals. It temporarily takes away the tension of having to fight homosexual impulses, and yields the emotional gratifications of feeling unique and *tragic*—and of course of having sexual adventures." Unfortunately, "[r]eal happiness, let alone inner peace, is never found that way. Restlessness will increase, as will the feeling of an inner void. Conscience will send out its disquieting and persistent signals" (p. 23; emphasis in original).

Van den Aardweg believes that for all persons with SSA, and experientially for persons for whom SSA is unwanted, discontent results from "the unhappy person" having "identified with . . . a false 'self'." For such a person, identification with a false self "is a seducing dream; in time it turns out to be a terrible illusion." For "'being a homosexual' means leading an unreal life, ever farther away from one's real person [self]" (p. 23).

Writing about *gender* vs. self-identity, Valdes (1996) explains that "the homosexual experience" for the adolescent or young adult male involves the "fusion"—one might also say *confusion*—of his experiencing an inability to identify with other males (in other words, a *lack of authentic gender identity*), with his emotional needs for autonomy and independence, and with directing his sexual energies toward males. Valdes explains:

> The emotions and feelings experienced by the boy during [the] period in which he struggles for independence, autonomy, and gender identity tend to become fused with each other making them appear to the child as if they were the same. . . . When the boy attains puberty, he uses his sexual drive, strongly perceived at this time, not to relate to the opposite sex, but to satisfy an unmet need for gender identity. (p. 348)

Valdes also observes that sexual identity confusion may result when a boy or a man misunderstands the nature of his felt "need to have sexual activity with another male." When a male becomes conscious of desire for "the homosexual experience," he commonly is unaware of authentic, unmet needs, such as *independence*, *autonomy*, and *individuation*, which may underlie this desire. In this sense, a boy's or man's gender identity needs may remain fused with these other basic needs. Valdes speculates that this "fusing of unmet basic needs might be one possible explanation as to why so many men report that they have felt the lack of gender identity from a very early age and have experienced themselves as different from other male peers as long as they can remember" (pp. 348–349). Consequently, "since this combination of needs resembles the basic emotional needs that he felt as a boy, he concludes that he is a homosexual, rather than recognizing that he has not attained gender identity" (p. 349).

Nicolosi (2009b) describes this experience in similar ways. For Nicolosi, "the homosexual impulse is also an attempt to rediscover the free, expressive, open,

powerful, gendered self that each man was created to claim. The intent of the impulse is 'reparative' in that its goal is gender affirmation; the man strives to be 'seen' by other men as an attractive male" (p. 33). Nicolosi (2009b) has also observed that many of his clients have come to therapy not "just to change their unwanted behavior," but "to change their sense of self." And some clients seek not just to diminish SSA, but to become "more heterosexual, and not just to 'act' heterosexually." Nicolosi explains that many male clients "want to feel comfortable in relationships with straight [non-homosexual] men" (p. 28).

In addition to being seen as an attractive, salient man by other men, many clients also want to learn to be seen by women as a salient man. Nicolosi (2009b) remarks that part of his clients' goal of fulfilling "their latent heterosexual potential" often includes learning "to hold onto their masculine autonomy with women" (p. 28). Van den Aardweg (1997) speaks about the same concern using different terms. He observes that the "*[f]ear of the opposite sex*" that is frequently experienced by both men and women with SSA may be "a symptom of *gender inferiority feelings*." Such feelings "can be activated by members of the opposite sex, who are perceived as expecting sex roles the homosexual feels unable to perform" (p. 20; emphasis in original).

Finally, as discussed earlier in this section, Baars (2008b) has noted the challenges and common negative consequences that result when anyone—particularly persons with SSA—identifies and tries to live according to a false sense of self in order to gain the love, attention, acceptance, and approval of others. Baars explains that *unaffirmed* persons who experience SSA commonly try to obtain *affirmation*—unselfish, life-giving love—in one of two ways:

> First, by *always being "nice" and pleasing others*, by *never getting angry*, and by *never hurting other people's feelings* [emphasis added]—in short by nonassertive behavior. Second, in sexual contacts using the

> mistaken notion that sex equals love. The more total the frustration of the fundamental need for affirmation, the greater the drive and the more desperate the *desire to bind another to oneself* [emphasis added] . . . . By and large, these sexual acts . . . represent a measure of the depth of a person's fundamental deprivation, since they indicate either the intensity of the *need to please others* . . . or the *fear of being rejected or considered "unmanly"* [emphasis added] in the "gay" world. (p. 192)

• ***Unmanaged or unresolved co-occurring compulsions and addictions—to, among other things, sex, alcohol, other drugs, and food—as well as disorders of mood (anxiety, depression) and personality.*** Gratifying SSA—as well as opposite-sex attractions—may serve a temporary, *self-medicating* purpose, allowing someone to temporarily numb or avoid experiencing one or more unwanted feeling states. If such behaviors become habitual, they are in some cases properly regarded as compulsive or addictive. In addition, persons with SSA may experience one or more psychological or behavioral difficulties, including diagnosable disorders, which themselves are problematic.

Regardless of whether SSA thoughts and behavior are unwanted, all sexual and emotional compulsions or addictions—whether motivated by SSA or not—are problematic in themselves and are difficult to manage or resolve. Whitehead and Whitehead (2013) describe how sexual addictions are essentially a drug problem caused by the repeated experience of pleasurable sensations caused by "drugs" (hormones and other chemicals) produced by the body. The repeated presence of these drugs, especially if they are associated with the relief of distressing emotions, commonly leads to a physical dependency on these drugs that the person comes to perceive as a need. Over time, the person may come to perceive their repeated use as an "uncontrollable compulsion." The Whiteheads note that while the physiology of one's cells does make it possible for a person to develop an addiction, the person enables this to happen

through repeated use. Thankfully, it always remains "possible to reverse the process and rediscover the old normalcy (or find a new one)" (p. 100).[9]

Considering SSA in particular, various therapists describe the potentially—and for too many persons, actually—addictive process of emotional and/or sexual addiction involved in gratifying SSA. For example, van den Aardweg (1997) comments: "Giving in to homosexual wishes [may] create a sexual addiction. Persons who have reached this stage [now] have essentially two problems: their gender inferiority complex and a relatively autonomous sexual addiction" (p. 20).

Fitzgibbons (1999) notes that "Increasing numbers of young people become involved in sexual experimentation and develop an addiction to same-sex activity" (p. 90). Reflecting on "the number of sexual partners, dangerous behaviors, and other negative aspects typical of the homosexual lifestyle," Fitzgibbons notes that for some persons, "*[s]exual addiction* may . . . be a major problem within the homosexual lifestyle" (p. 96).

Compulsions and addictions develop because, while the experience of physical or emotional pleasure and emotional relief—sometimes called self-calming or self-soothing—may be intense, the feelings do not last and may leave greater discomfort after the biochemical-induced high has faded. Valdes (1996) describes this process for male adolescents:

> [W]hen the adolescent feels a sense of failure, rejection, lack of acceptance, powerlessness, and so on, he is inclined to meet those needs by eroticizing

[9] The research and theorizing based on the Trans-Theoretical Model of Intentional Behavior Change, or TTM (DiClemente, 2003; Prochaska, Norcross, & DiClemente, 1995), is recommended for understanding in more detail how persons may develop and also may be helped to change *any* behavioral habit, compulsion, or addiction.

> them—usually resulting in some form of sexual acting out, as if by this acting out, he would gain acceptance by males in general. (p. 348)

"Most of the time," sadly, "after acting out, [the adolescent] discovers that he feels worse and that the sexual gratification did not satisfy any of his needs" (pp. 348–349).

Valdes explains further that "sexual acting out to fulfill the unmet needs of gender identification has a negative effect." This occurs largely because "relating only to members of the same sex who exhibit a similar condition will not satisfy the gender identity unmet need because they have the same kind of deficit." Unfortunately, engaging in such behavior "does not heal the condition but rather perpetuates it and makes it even more addictive" (p. 364).

Nicolosi (2009b) observes that for men, "homosexual acting-out is an attempt at restoring [the person's] psychic equilibrium. Through an erotic connection with another man, they unconsciously seek to attain a self-state characterized by assertion, autonomy, and gender-relatedness." Regrettably, this attempt works only temporarily at best. In Nicolosi's experience, the men he serves find that behaving in this way "eventually brings them none of these things—only a nagging feeling of inauthenticity, and still deeper discouragement" (p. 33). Ultimately, while such acts may be momentarily exhilarating, "the brief, false vitality our clients feel when engaging in sex with other men . . . is not satisfying for very long: in fact it is compulsive, stereotypic, and repetitive" (pp. 34–35).

Hallman (2009) has observed a compulsive or addictive quality to the patterns of emotional dependency and overinvolvement commonly experienced by the women with SSA whom she has served. Hallman observes:

> This addictive way of relating [in which the female client] most likely medicated powerful emotions through her overattachments [must be addressed]. . . . She has a legitimate drive for relational connection and

> intimacy [but she must learn to] relate to others in the limited doses that they are able to offer. Her pattern of developing instant [emotional] intimacy must be broken and replaced with relationships—plural, not just one—that evolve over time. (p. 150)

In addition to experiencing sexual addictions, persons with SSA commonly experience a number of psychological or behavioral difficulties, including diagnosable disorders, several times as frequently as do persons without SSA (NARTH, 2009; Phelan, et al., 2009; Whitehead, 2010).[10] The abstract of Neil Whitehead's (2010) article, "Homosexuality and Co-morbidities," is worth quoting at length:

> Clients with unwanted SSA . . . who present to therapists, often have co-occurring problems. . . . [A] score of mental health conditions are present in the general SSA population at rates three or more times greater than in the OSA [opposite-sex attraction] population, involving almost every DSM *[Diagnostic and Statistical Manual of Mental Disorders]* category. These conditions include bipolar, OCD [obsessive compulsive disorder] and schizophrenia, but are predominantly mood disorders, depression, substance abuse and suicidality. . . . People reporting SSA have a more widespread and intense psychopathological burden than probably any other group of comparable size in society, though college-age people may have more substance abuse. . . . Surveys in recent literature suggest objective discrimination is not to blame for suicidality, but

[10] The Phelan, et al. (2009) and Whitehead (2010) references list many studies that document the nature and relatively higher frequency of a number of *co-occurring* (also called *comorbid*) medical, psychological, and behavioral difficulties and disorders among those with SSA as compared with persons who do not engage in same-sex gratifying behaviors.

> *perceived* discrimination. . . . [P]articular emotion/avoidant based coping mechanisms used by people reporting SSA almost entirely account for the effects of this perceived discrimination. (p. 125; emphasis in original)

VI. To be helpful, professional care—including medical and mental health services, including therapy, counseling, guidance, and education—for unwanted homosexuality, like all professional care for any presenting concern, must be given personally, one client at a time, to those who freely seek it.

Over the past century and a half, the medical and mental health arts and sciences have changed in their understanding of how homosexuality may develop and how unwanted SSA may be managed and alleviated. As discussed previously, clinicians and scientists have described many possible causes and have offered various theories in order to try to either explain homosexual behavior or to suggest how the desire to engage in such behavior may be prevented or remediated if the person experiencing them seeks such assistance.

Abbott and Byrd (2009) offer a useful perspective in understanding the possible but limited relevance of the diversity of theories and research findings that exist:

> In general, theories are explanations of why we behave as we do (Green & Piel, 2002). Theories give us clues about possible causes of behavior (White & Klein, 2002). If causes can be identified then intervention and remediation can (or may) occur. . . . This solution, of discovering and then controlling causes of behavior, is not as simple as it appears, because most complex social behaviors (such as those associated with . . . homosexuality) are influenced by multiple factors acting over many years. Identifying and controlling one or two causes that may contribute to the undesirable behavior may not be enough to prevent the (re-)occurrence of that unwanted behavior. (p. 19)

Effective professional care to any person for any presenting problem is an art and requires a truly interpersonal—in other words, person-to-person—relationship focused on helping a client meet his or her realistic goals as he or she defines them. Mental health professionals wisely recognize and encourage their clients' individuality and their need, duty, and right to make their own decisions. Serving clients as such begins with making possible the client's authentic *informed consent.* As Hamilton and Henry (2009) write, obtaining informed consent from clients means

> explaining clearly the realistic possibility of change, including the limitations, and the often difficult process of therapy. Therapists should . . . present [clients] with realistic expectations: that change is not easy; that it is an ongoing process; and that, as with any issue, it often takes time [and] . . . that they may not experience change to the fullest degree that they desire. (pp. xxii–xxiii)

In order to ensure that clients not feel or "be forced or coerced into changing," possible clients or patients "should be given full and accurate information" in order to "determine their own therapeutic goals" (p. xxiv).

Byrd (2009) explains that "describing one's approach to psychological care" in general is inherently difficult. "Whatever the approach, it must [be] adapt[ed] to the particular patient" and his or her unique needs, concerns, and life circumstances (p. 84). Psychological care for unwanted SSA is no different.

Mary Beth Patton (2009), who works exclusively with women, comments similarly:

> My client has the right to self-determination. As an adult I respect her ability to make decisions for herself. She [typically] has been wounded by

> the over-control of others and I want to be sure not to repeat that pattern. Collaboration is my goal. I am the expert on the big picture; she is the expert on herself. . . . She needs to know and be assured that I am invested in her good. My goal is to delight in her as a person and in her uniqueness (not just in what she can [or cannot] do). (pp. 91–92)

Those who work primarily with men with unwanted SSA offer similar comments. Byrd (2009), a psychologist trained in interpersonal and cognitive behavioral therapy, notes:

> In many ways, providing psychological care for men who present with unwanted homosexuality is not very different than dealing with other patient populations: the therapist begins where the patient is and demonstrates respect for patient autonomy, patient self-determination and diversity. (p. 84)

Respect for client diversity means not imposing treatment on clients, regardless of whether the treatment seems reasonable to the therapist. Respect for client well-being and the ethical duty of beneficence and nonmaleficence (doing good and avoiding harm) also require that therapists not yield to demands by clients for unreasonable treatment—for services that either are not beneficial or may be harmful.

VII. Homosexual feelings and behavior are not innate or immutable, and homosexual behavior is not without significant risk to medical, psychological, and relational health.

As mentioned previously, the APA (1998, 2008) acknowledges that homosexuality is not "innate"; that psychological and social factors, as well as genetic and other biological factors (both nature and nurture) influence the development of homosexuality.

In other words, persons with SSA are *not* "born that way"! Also, while the APA claims that there is insufficient empirical evidence to show that sexual orientation itself may be changed through therapy or other means (such as pastoral intervention), the APA (2009) does acknowledge that sexual behavior, attraction, and orientation identity are "fluid"—in other words, not fixed or immutable. While the APA warns potential consumers that "sexual orientation change efforts" (SOCE) *may* be harmful, their 2009 report also concludes: "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" (p. 83, cf. 2, 3).

In a proactive response published several months before the anticipated 2009 APA report, the National Association for Research and Therapy of Homosexuality (NARTH) reviewed more than a century of experiential evidence, clinical reports, and research literature. NARTH's report, "What Research Shows" (Phelan, et al., 2009; NARTH, 2009), documents

- that it *is* possible for both men and women to change from homosexuality to heterosexuality, both with and without professional assistance[11] (cf. Whitehead and Whitehead, 2013);

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[11] "What Research Shows" (NARTH, 2009) reviews 125 years of clinical and scientific reports documenting that professionally-assisted and other attempts at volitional change from homosexuality toward heterosexuality have been successful for many and that such change continues to be possible for some who are motivated to try. "Clinicians and researchers have reported positive outcomes after using or investigating a variety of . . . paradigms and approaches . . . to treat homosexuality, including *psychoanalysis, other psychodynamic approaches, hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, pharmacology* [emphasis added], and others. In many cases, combinations of therapies have been used. There have also been reports of spontaneous change, i.e. of persons experiencing various degrees of 'sexual reorientation' without professional or pastoral guidance." (p. 2)

- that efforts to change are not unreasonably or unacceptably harmful; and

- that homosexual men and women *do* indeed have greater risk factors for medical, psychological, and relational problems than do the general population (cf. Diggs, n.d.; NARTH, 2009; Whitehead, 2010).

It is important to acknowledge that *everyone* who has attempted to change the feelings, thoughts, or behaviors associated with unwanted SSA—with or without professional assistance—has *not* accomplished his or her goals as completely as he or she intended. Yet it is also important to remember that many clients seeking to resolve unwanted SSA have accomplished their goals to greater or lesser degrees (cf. Phelan, et al., 2009, pp. 12–280). *Some* persons who have experienced SSA—including some who once fully "lived the lifestyle"—*have* learned to live serene lives without homosexual gratification. And *some* of these *have* developed their heterosexual potential enough to now be married with children. NARTH (2012) offers a helpful perspective for understanding the possibility of change of unwanted SSA:

> NARTH believes that much of the expressed pessimism regarding sexual orientation change is a consequence of individuals intentionally or inadvertently adopting a categorical conceptualization of change. When change is viewed in absolute terms, then any future experience of same-sex attraction (or any other challenge), however fleeting or diminished, is considered a refutation of change. . . . Rather than pigeonholing homosexual sexual orientation change into categorical terms, NARTH believes that it is far more helpful and accurate to conceptualize such change as occurring on a continuum. . . .

> NARTH affirms that some individuals who seek care for unwanted same-sex attractions do report categorical change of sexual orientation. Moreover, NARTH acknowledges that others have reported no change. However, the experience of NARTH clinicians suggests that the majority of individuals who report unwanted same-sex attractions and pursue psychological care will be best served by conceptualizing change as occurring on a continuum, with many being able to achieve sustained shifts in the direction and intensity of their sexual attractions, fantasy, and arousal that they consider to be satisfying and meaningful.[12]

As mentioned above, research shows that attempting to change unwanted SSA does not subject a client to unacceptably high risks of "harm." There have been recent and are current efforts by legislatures and professional bodies at the state, national, and international levels to attempt to stop medical and mental health professionals from offering assistance to "change unwanted SSA." Legislation and pronouncements by professional bodies commonly cite one or more studies in support of their efforts to prevent potential clients from receiving and professionals from offering such assistance. Typically, such research has been reported in a manner that ignores the studies' authors' own awareness of the studies' methodological limitations and irresponsibly claims that the research says more than it does. Too often, ideological bias and irresponsible science or concerns about ethical, professional practice appears to be driving such legislative and professional activism.

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[12] Firsthand testimonies of former clients who have sought and gratefully recount their experience of receiving such professional care may be read, heard, or viewed at PATH (n.d.), www.voices-of-change.org

For example, the study by Shidlo and & Schroeder (2002) is commonly cited as "proving" that professional efforts to change unwanted SSA are unacceptably harmful. While this study *may* offer legitimate examples of real, unwanted negative consequences experienced as a consequence of persons who participated in "conversion therapy"—one of several generic names commonly given by critics to the practice of professional and nonprofessional assistance for unwanted SSA—it offers no proof of anything. As Shidlo and Schroeder themselves comment: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (p. 250; emphasis in the original). In spite of such a responsible qualification about the meaning of the results of their study, activists within state, national, and international bodies have irresponsibly used this study to attempt to ban professional "conversion therapy" (Rosik, 2013a, 2013b; Sutton, 2014).[13]

A foundational principle for ethical and beneficial practice by all medical and mental health-care professionals is *respect for clients' and patients' right to "self-determination.*" As Principle E: Respect for People's Rights and Dignity of the APA (2010) Ethical Principles states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." Surely, this must include the rights of persons to choose to manage and diminish same-sex attractions and behaviors, and perhaps even try to foster opposite-sex attractions and behaviors!

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[13] A decade later, several studies conducted with methodological weaknesses similar to the Shidlo and Schroeder study also attempt to "*document the harm*" (Shidlo and Schroeder, 2002). Undoubtedly, it is only a matter of time before one or more state, national, or international legislatures or professional bodies uses one or all of these new studies in attempting to discredit and prevent the professional practice of change-oriented professional care (Rosik, 2014).

Ironically, on paper, the APA (2009) would seem to agree with NARTH (2010) and allied medical and mental health professionals about the importance of a therapist respecting the "dignity and self-determination of all their clients, including those who seek to change unwanted same-sex attractions and behavior" (Practice Guideline 4). Unfortunately, in practice, the APA and other medical and mental health professional associations seem bent on limiting such self-determination.[14]

When considering the ethics of whether, when, and how to offer professional help to persons whose experiences of SSA feelings, thoughts, behavior, lifestyle, and/or identity are unwanted, the uniqueness of the person who is a potential or actual client must always be remembered. In addition to the ultimate uniqueness of the influences and experiences associated with each person's development of SSA—and indeed, opposite-sex attraction—each person who experiences SSA as unwanted likewise does so out of personal, if sometimes also common, motives. For example, Julie Harren Hamilton and Philip Henry (2009), coeditors of the *Handbook of Therapy for Unwanted Homosexual Attractions*, explain that clients who seek help to cope with and resolve unwanted homosexual attractions may do so for a variety of reasons, such as "a lack of fulfillment in their homosexual identity, incongruence with personal values, deeply held religious beliefs, personal goals of heterosexual marriage and children, and many other such internal motivators" (p. xxi).

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[14] As the APA 2009 report states, licensed mental health providers (LMHP) "should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments" (p. 76). "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" (p. 69), and that "clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns" (p. 63). Ironically, professionals who do wish to assist clients or patients in changing unwanted same-sex attractions and behavior are able to agree, in theory, with each of these APA assertions (cf., NARTH, 2010).

Other internal motivators may include realistic concerns about preserving or reacquiring one's medical, psychological, and/or relational health. The evidence of increased medical, mental, and relational health risks for those engaging in SSA behaviors compared with those who don't is significant and alarming. Those risks include a myriad of medical problems and diseases directly related to homosexual practices; AIDS and other STDs; substance abuse; suicidal ideation and attempts; psychological and psychiatric concerns including depression, anxiety, paranoia, personality disorders, and eating disorders; and same-sex relationship violence (Phelan, et al., 2009, p. 87; NARTH, 2009, p. 4). Such risks—and a client's self-determination to reduce or avoid them—must be borne in mind by professionals, pastors, and lay persons who are in a position to offer help, whether such helpers in general support or oppose offering therapy or other professional care to help persons manage or resolve unwanted SSA. As the NARTH (2010) Practice Guidelines recommend, potential helpers are advised to seek adequate education, training, and supervision, both before and while offering such care.

VII. Concluding remarks

While I am a psychotherapist trained in clinical psychology and marriage and family therapy, this paper was not intended to and does not offer practical suggestions for *how* to help people who freely choose to act or live differently to understand, manage, and to a greater or lesser extent diminish unwanted SSA. The *pragmatics* of assisting people to change how they think, feel, and act relating to SSA has not been my main concern here; others have written elsewhere about the ethics, nature, and efficacy of psychological and pastoral care for unwanted SSA (e.g., Baars, 2008b; Byrd, n.d.; Consiglio, 2000; Fitzgibbons, 1996; Hallman, 2008; Hamilton & Henry, 2009; Jones & Yarhouse, 2011; Nicolosi, 2009a; Valdes, 1996; van den Aardweg, 1997). My intent has been to discuss the issues—including the potential risk factors and bio-psycho-social

realities—that men, women, and children with unwanted SSA may have had and/or may still have. I hope that this discussion offers understanding and helpful guidance to the medical and mental health professionals to whom persons with unwanted SSA may come seeking assistance. I also hope that persons who experience SSA, and anyone whom their lives touch, may come to better understand SSA.

In closing, I am mindful of some of the basic questions that are answered and lived out in some way by each person inevitably, but perhaps unreflectively. What does it mean to be a (male or female) human being? Is it good to be a (male or female) human being? What is the proper role and meaning of mothering—and fathering—in *biological*, as well as *spiritual* (including *psychologica*l) parenting, in the lives of children and the adults responsible for their procreation—and education? How necessary are permanence, fidelity, and fecundity to the relationship in which one experiences sexual gratification—and, at least potentially, engenders and nurtures to adulthood a new human being? I think that one's answers to such questions, whether consciously known or not, both affect and are affected by the development of SSA.

It may be helpful for anyone who aspires to love anyone who experiences same-sex attractions (including oneself) to realize that *how* one defines or describes the *essential nature* of every human being—and especially one's own or one's loved one's *fundamental identity*—significantly influences how one deals with life in general, and one's sexual attractions in particular. I think it is foolish—as well as untrue—to define oneself by one's "sexual orientation." Believing that the most important characteristic of one's self is whether one is attracted emotionally and/or sexually to and experiences sexual gratification, only or primarily, with members of one's own sex—or even of the opposite sex—is reductionistic, demeaning, and ultimately self-defeating. More fundamental than one's sexual orientation is the fact that one is a human being with intrinsic dignity and worth that precedes and co-occurs with any particular experience or expression of one's sexuality.

This reminder of the intrinsic personhood, dignity, and worth of every human being, including anyone who experiences SSA, serves as a fitting ending to this paper. While there appear to be common experiences and bio-psycho-social issues shared to a greater or lesser extent by some—sometimes many—persons who experience SSA, each person has his or her own story. Every human being warrants respectful and compassionate attention, understanding, and—if desired—care to "be(come) who he or she is," and to live accordingly. Whether one is a medical or mental health professional, pastor or civil servant, someone with unwanted SSA, and/or someone who is simply personally concerned, all persons are challenged to attempt to understand and honor the person, story, and life of each man or woman we encounter.

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Prenatal Hormones Are Only a Minor Contributor to Male Brain Structure in Humans

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Abstract

The work of Phoenix, Goy, Gerall, & Young (1959) as well as later supporting research has been taken as evidence that the male brain is prenatally masculinized by testosterone but only activated to full heterosexual orientation at puberty. This conclusion was based on experiments in which testosterone was injected into pregnant guinea pigs and the female offspring subsequently examined. It has been widely assumed, though perhaps mistakenly, that a prenatal testosterone surge is also the major cause of male sexual orientation in humans. Subsequent research—including studies of the congenital adrenal syndrome (CAS) in girls—has shown multiple influences from a variety of sources on animal/human adult heterosexual orientation and brain structure, making such a theory too simplistic.

Recent work in the UK (Lombardo et al., 2012), testing the Phoenix et al. theory quantitatively for the first time, is here interpreted to show that the prenatal testosterone effect exists in humans at only 16 to 27% of total influences, so it is weak to modest, not major. Two other types of independent calculation in the Lombardo et al. paper, from twin studies and age of first sexual attraction, support the modest size of the influence. This implies that heterosexuality in humans does not develop solely under the influence of testosterone, but probably requires environmental inputs, which include those from parents and peers.

Homosexuality and transgender orientations have been assumed to be due to prenatal disturbances in testosterone hormone exposure, but the Lombardo et al. result for heterosexuality implies that prenatal influence is at best weak to modest for homosexuality and transgender. The fact that research is increasingly revealing multiple influences makes parenting important and sexual therapy a possibility.

Introduction: Experimental Work by Phoenix et al.

Hormones are important molecules in cells; apart from their various regulatory functions in the adult animal, such as regulation of sexual function, they are involved in the growth and maturation of the fetus. How and to what extent these prenatal hormones—particularly testosterone—influence actual adult sexual behavior has been unclear, and many theories have emerged over the course of time. The purpose of this paper is to discuss the most popular, a theory advanced by Phoenix et al. (1959).

Building on work published by others just before World War II, Phoenix et al. (1959) exposed pregnant guinea pigs to varying amounts of the male sex hormone, testosterone propionate. The male young seemed little different from controls, but the female young with the highest testosterone doses were "hermaphrodites," having masculinized genitalia and showing little or no lordosis, the submissive posture during mating. Further, during mating the adult females tended to mount other females as males would at a 75% rate; that was a very significant difference compared with a rate of 10.5% for female control guinea pigs. These effects resulted in some sense in same-sex attraction (SSA) behavior in the female guinea pigs. In hundreds of subsequent papers by others, this behavior has been equated with sexual orientation. Although this is dubious, because the mental state of the animal is not accessible to observation, this paper allows the equation for the sake of review only.

Changed behavior occurred in six animals out of one experimental group of eight. This immediately shows that the same treatment had variable effects and did not necessarily create the mounting behavior every time. Similarly, the doses sufficient to suppress lordosis in all animals produced hermaphrodites. If testosterone doses were lower and did not produce hermaphrodites, the lordosis was suppressed in only 50% of the animals. The control animals developed opposite-sex attraction (OSA), whereas for SSA, the authors commented, "Within each group the effect on lordosis was not related to the quantity of androgen received prenatally" (p. 373), so the SSA production was quite erratic. That point will be relevant to further discussion of SSA later in this paper.

The impression often given by reports of animal work is that complete and reproducible changes of sexual orientation occur with experimental treatment. In fact, however, such changes in sexual orientation rarely occur with experimental treatment, and there is much overlap in behaviors, regardless of how they are produced. Statistical methods must often be used to detect these differences.

The main conclusion of the authors was about OSA, although their work had produced a kind of SSA. They wrote that there exists "an organizing or 'differentiating' action on the neural tissues mediating mating behavior. During adulthood the hormones are activational" (p. 369).

The guinea pigs did not show sexual attraction characteristics when born; after a period of dormancy, sexual orientation emerged—in other words, was activated—only at puberty. As a result, the theory became known as the *organizational-activational hypothesis*. That hypothesis has been very influential and has been cited at least 950 times. It fits the universal observation that mammalian young of all species show any type of sexual attraction only well after infancy, around the time of puberty. However, the hypothesis raised many questions, particularly whether guinea pig metabolism reflected human metabolism well and whether the experimental results might have merely indicated pathological damage to the central nervous system of the animals.

Subsequent Experimental Work

Relatively little further work was done with the guinea pig, because the rat was a more convenient laboratory animal. But it rapidly became clear that the sensitive period for added hormone exposure was a little different in rats—it was not restricted to prenatal times, but also occurred from just before birth to a few weeks after birth (McCarthy, Wright, & Schwarz, 2009). It also became clear that for rats, the masculinizing hormone needed was not testosterone but estradiol, a hormone more usually associated with the female reproductive system. This showed that the postnatal influence of hormones

could be important for brain development, but this has not been thoroughly investigated for many species. Other work on rats showed there were even strain differences for sensitivity to some sex hormones (McCarthy et al., 2009).

The adult brain differences found in the last several decades were discussed by de Vries (2009). Although anatomical brain sex differences are known for different species, they commented that in most cases we do not understand how or even whether these sex differences contribute to sex differences in behavior. In many species, a brain structure called the sexually dimorphic nucleus (SDN) in the preoptic area (POA)—part of the hypothalamus—is essential for male behavior in many animals, yet surgical procedures that destroy the SDN in male ferrets have no effect (McCarthy et al., 2009). Female ferrets have no SDN nucleus at all, but their behavior can still be manipulated with testosterone, casting doubt on whether the brain structure is even relevant in other species. Mice do not have an SDN difference and still show sexual preferences (de Vries, 2009). Any overview would have to highlight the interspecies diversity that is present. This type of diversity casts further doubt on whether animal models apply to humans.

In a study that showed similar diversity, Schulz, Molenda-Figueira, and Sisk (2009) found evidence in some experimental animals that there was a single extended postnatal sensitive period for steroid-dependent organization of male reproductive behavior; that period began around birth and ended in late adolescence. This was quite different from what occurs in guinea pigs and different from what occurs in rats. They also found that social experience affected both brain and sexual behavior in animals. The primate brain seemed rather similar to the rat brain in its reactions to sex hormones (Wallen, 2005), but, unlike the case for the rat, estradiol was not uniquely important. Some types of masculine behavior seemed completely dependent on maternal socialization; others seemed independent.

Obviously, then, there were differences from one species to another, and some postnatal influence seemed to arise from hormonal effects produced in offspring by

maternal grooming. Even so, it was unclear how strong this effect was compared with the presumed instinct to reproduce. It might be predicted that although humans may have the same basic hormonal framework—such as the importance of steroid sex hormones—the importance of socialization and learning would be much greater and the influence of hormones would be less. *Homo sapiens*, after all, is the learning animal *par excellence*.

Although the varied patterns of animal structure/function should have led to caution, it was popularly assumed that the Phoenix et al. findings applied to humans. It was also assumed that fetal testosterone was an overwhelming influence, because the existence of a prenatal testosterone surge was well known in humans (Hines, 2008) and because young children were not attracted to the opposite sex until around puberty. This implied a complete cessation of hormonal influence during this time, something that seems unlikely. However, as described by Byne and Parsons (1993), even by the mid-eighties—about fifteen years after the work of Phoenix et al.—the academic consensus from all available results was that nature/nurture interaction was the origin of sexual orientation rather than exclusively nature *or* nurture. We must note, then, that a belief in the overwhelming importance of either nature *or* nurture in the scientific literature was not mainstream opinion in the eighties, and still is not.

Human Adrenogenital Syndrome

This section is presented at this point because the work was done a few decades ago and is useful background for current findings. Direct human experimentation, such as testosterone injections into pregnant women, is not ethically possible. However, at least one long-acknowledged medical condition—the congenital adrenogenital syndrome (CAS)—shows the influence of prenatal sex hormones, but its relevance to the Phoenix et al. hypothesis has received little attention.

CAS girls are exposed prenatally to about nine times the normal concentration of androgens as a result of overactive adrenal glands (Wudy, Hartmann, & Homoki, 2000),

and they are born with masculinized genitalia. They are thus very much like the Phoenix et al. guinea pigs that were given the highest testosterone doses. In the guinea pigs, these doses created females that had many male behaviors. In the CAS girls, perhaps the most relevant comparison would be the occurrence of lessened heterosexual orientation, such as lesbian/bisexual sexual orientation. A reasonable estimate of the prevalence of this sexual orientation in CAS girls is about 10 to 20%, and about 10% of CAS girls actually wanted sexual reassignment surgery that would change them to males (Whitehead & Whitehead, 2010). This is a much smaller influence than the 75% of female guinea pigs who mounted other females or the 100% who did not show lordosis; it may be another example of species differences. But these differences suggest that factors other than testosterone may also be important in humans, such as upbringing, peer interaction, and cognitive factors.

Current Evaluation of Phoenix et al.

On the fiftieth anniversary of the publication of Phoenix et al., a 2009 issue of the journal *Hormones and Behavior* was devoted to discussion of the theory. McCarthy et al. (2009) offered the following commentary:

> In this time, the dogma that has emerged is, simply put, that developmental exposure to gonadal steroids acts on the brain to organize the neural substrate that is then selectively activated in the adult to induce expression of sex specific behavior. This elegant synthesis effectively explained a collection of disparate data and provided a framework against which future work could be read. Evidence in support of the essential truths of the hypothesis have [sic] steadily accumulated over the intervening 50 years, but evidence challenging or refuting the hypothesis has piled up in an equally compelling fashion. (p. 1)

They also commented that the field needed clarification, saying, "We do not even know what a female brain is other than it is not male" (p. 6). In their commentary, the authors deplored undue adherence to the "dogma."

In the same volume of *Hormones and Behavior*, Diamond (2009) considered the hypothesis certain for nonhumans and almost certain for humans—a position that seems one of the more extreme unless other influences are also admitted. He mentioned that initially the case of transgender people seemed a refutation of the theory because they were apparently not subject to unusual hormonal conditions *in utero*, as judged by their typical genitalia—but their brains apparently developed a sexual orientation opposed to their chromosomal status. Diamond and others therefore advanced a hypothesis that there was a later period in gestation, after the testosterone surge, during which "brain gender" could be fixed or preprogrammed in the brain in a manner different from the earlier time during which genitalia development needed testosterone. Such a period was found in primates (Wallen & Hassett, 2009), but there remained no direct experimental support in humans. Results reviewed later in the present paper show that, in fact, there is some contrary evidence of such a later period existing in humans. The theory was also incomplete because it did not allow for postnatal hormonal influence, already known for some animal models.

According to a subsequent publication (Semaan & Kauffman, 2010) that described the animal models, the "majority of known sex differences are induced by the sex steroid milieu during early postnatal development" (p. 3). In other words, most sex differences do not originate prenatally. It remained unclear to what extent this applied to humans.

Research on Newborn Children

According to the original theory, although young children have brains prenatally organized as male or female, they do not express sexual behaviors or attractions until puberty (in 1959, when the original theory was postulated, there was little knowledge of

postnatal effects of hormones on the brain). However, researchers still sought for gender-dimorphic behavior in children too young to be affected by parental input. Although there was a slight difference in size between male and female newborn brains, there were very few other differences in actual brain anatomy, and sexual differentiation in brain anatomy seemed to start in a very subtle way only at about age four. It seemed any differences must be at the level of the cell biochemistry rather than the anatomy, though it was also possible that an age of four would have allowed for extensive socialization effects.

However, some behavioral differences are apparently observed. In the first four days after birth, girls imitate parents faster and more often; they also pay more attention to the cries of other babies (Hoffman, 1977). There is a definite difference in sleep/wakefulness maturation that lags in boys (Cornwell, 1993). Newborn girls also have a greater sensitivity to electric shock, react more to a puff of cold air on the skin, and make more fine gestures, according to Nagy, Kompagne, Orvos, and Pal (2007). In all these comparisons, the differences are statistical rather than sharply divided by gender, and there is considerable overlap. The two sexes are more similar than different, but the above features provide some very limited evidence for differences in gender behavior that originate in the brain prenatally. Because of possible environmental influence, comparisons made well after birth may not be valid, and possibly become less valid the later the test.

Human Fetal Testosterone Measurements

The ideal human experiment for comparison with the guinea pigs would be something like measurement of human fetal testosterone and monitoring the children after birth to see if brain structure at puberty reflected the fetal levels. Results of a program of investigation like this have recently been published and are now discussed.

Human fetal testosterone can now be measured during pregnancy in a procedure called *amniocentesis*, in which samples of amniotic fluid are withdrawn from pregnant

women. While the procedure was generally intended for genetic testing, some researchers take advantage of it, after obtaining consent, to analyze the amniotic fluid for testosterone. The levels of testosterone in the fetus show whether there is a prenatal surge and the size of such a surge. Subsequently, some researchers applied a battery of tests to the same children as long as eleven years after they were born to determine whether there was a correlation between testosterone exposure and gendered behavior. Some Dutch research was done, but much of the research comparing fetal testosterone and brain structure at puberty was done in the Autism Research Unit at the University of Cambridge under the direction of well-known chief researcher Simon Baron-Cohen.

Outcome after Birth

In a series of papers over a decade, Baron-Cohen and others have shown correlations (though often small) of fetal testosterone with many male-related traits at various ages. These included correlation inversely with degree of eye contact (Lutchmaya, Baron-Cohen, & Raggatt, 2002a); inversely with greater vocabulary (Lutchmaya et al., 2002b); positively with the 2Digit/4Digit finger-length ratio (Lutchmaya, Baron-Cohen, Raggatt, Knickmeyer, & Manning, 2004); inversely with empathy (Chapman et al., 2006); positively with autism (Auyeung et al., 2009a; Auyeung, Taylor, Hackett, & Baron-Cohen, 2010); positively with male-type child play (Auyeung et al., 2009b; see also Knickmeyer et al., 2005, and van de Beek, van Goozen, Buitelaar, & Cohen-Kettenis, 2009); positively with hand strength (Lust et al., 2011); positively with some visuospatial ability but not mental rotation (Auyeung et al., 2012); and positively with brain lateralization and male-type brain gray-matter features using MRI scans (Mercure et al., 2009; Chura et al., 2010; and Lombardo et al., 2012, the latter paper being particularly important). Some of these tests were done on eight- to eleven-year-old children, obviously long after the fetal testosterone measurements were taken. Any results directly measuring sexual attraction have not thus far been published.

A Correlation Is Found, but Further Research Is Indicated

So we can now test directly whether fetal testosterone correlates with sexually dimorphic anatomical structures, particularly finger-length ratios and brain structure (Lombardo et al., 2012). What is the result? Most importantly, there is a statistically significant correlation between prenatal testosterone exposure and late childhood sexually-dimorphic brain structure, a correlation that supports the organizational/activational hypothesis. However, the results are rather puzzling compared with previous literature. The authors found three sexually dimorphic brain regions in which the gray matter was proportional to fetal testosterone, but the regions are not those traditionally found in sex-difference research, which generally studies the amygdala and the hypothalamus. The authors found the size of the usual sexually dimorphic regions in the amygdala and hypothalamus were not related to fetal testosterone, perhaps because of postnatal hormonal influence. On the other hand, one region in the amygdala whose size was related to fetal testosterone was not sexually dimorphic. This is not what those in the field would expect, and replication would be reassuring.

Those who have followed similar studies over the last few decades will be hesitant to accept these brain structure results until replicated, because much brain structure work has failed that test. For the purposes of this paper, however, the results are tentatively accepted.

Although the authors emphasize that their work shows a link between fetal testosterone and brain regions, they do not think testosterone is the only influence. They invoke later—in other words, postnatal—androgen surges, epigenetic effects (influences from the environment), and a possible influence from placental sex hormones. This again demonstrates the current thinking that multiple influences are involved.

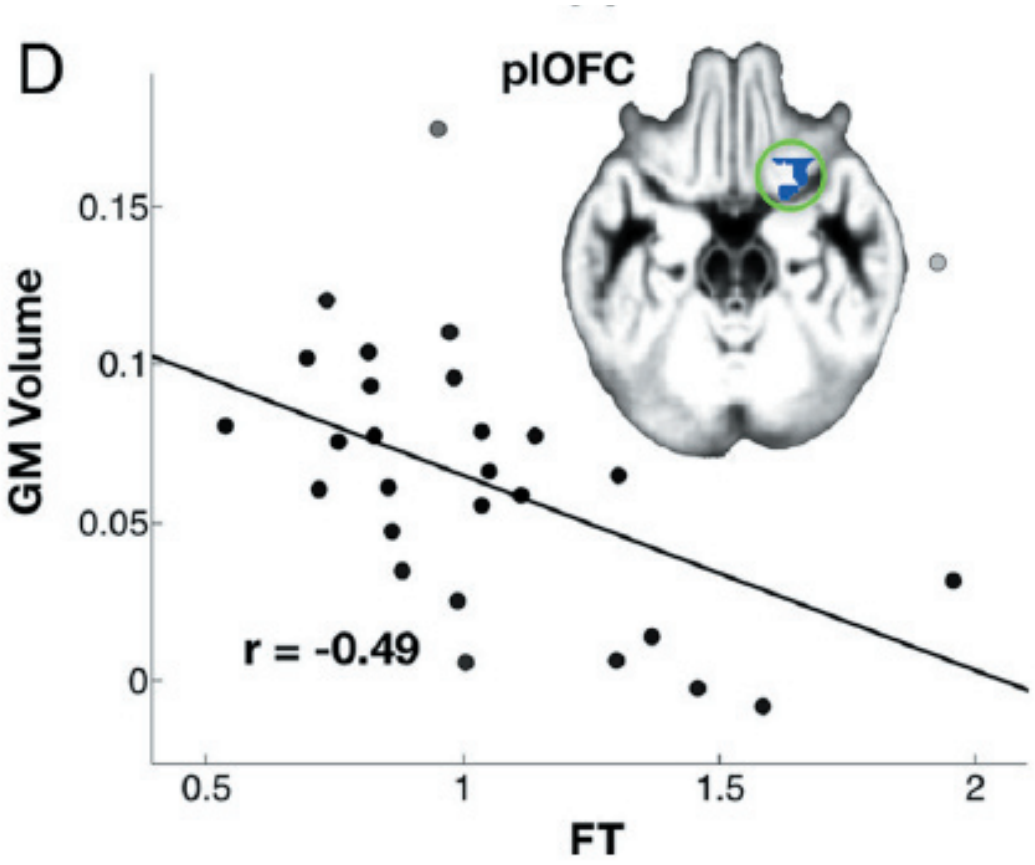

Figure 1.The (negative) association between one brain region (gray matter volume of posterior lateral orbito-frontal cortex) and fetal testosterone. Taken from Lombardo et al. (2012). The pale green circle encloses the blue-colored area that is the relevant brain region.

Strength of the Correlation

The data scatter, hence the strength of the correlation, is identical for the three brain regions within error. Correlation coefficients range from 0.45 to 0.49 (compared with a maximum 1.0 for perfect correlation), a statistically real effect. However, looking at Figure 1, it is clear that there is quite a degree of scatter in the relationship and probably a lognormal distribution; the strength of the correlation may be overstated. The brain structure gray matter volume is not rigidly dependent on the fetal testosterone. (A similar strength of correlation is found for the finger-length ratios.)

To find the degree of influence, fraction of variance explained, or scatter explained by the regression, the correlation coefficient is squared. That shows only 16 to 27% of the total variance (roughly total influences) on finger-length ratio and brain structure is explained by fetal testosterone; 73 to 84% is left unexplained. This makes the fetal testosterone influence weak to modest at best. The authors do not go as far as mentioning that or other possible implications.

The above calculation used the maximum correlations from the published papers of the Dutch and UK researchers. The other correlations between fetal testosterone and later male traits, such as autism, were much weaker or nonexistent; therefore, many proposed links are not supported by experiment. Another major caveat is that the brain scans were done well after the known human six-month *post*birth testosterone surge, which was not assessed by Simon Baron-Cohen and his team. The fetal testosterone association could ultimately prove to be weaker in its effects than the postbirth testosterone association.

An Adequate Test of the Organizational-Activational Hypothesis?

The paper by Lombardo et al. is particularly important because the researchers explicitly put their research forward as a test of the Phoenix et al. hypothesis for the brain—the idea that the "male brain" is fully organized prenatally but activated at puberty. At this point, some readers may be puzzled that the testing on the children was done between the ages of eight and eleven—that is, before puberty. The authors did agree in the text that puberty would be an important area of focus for future work and would probably involve a more precise test.

Two comments should be made. First, it was possible that even in late childhood there would be some correlation, and that is exactly what the authors found. This result almost demanded to be published. The second is more complicated: eight to eleven may have been an appropriate age range because quite significant literature now maintains that

the average age of first attraction—hence sexual orientation—to either the opposite sex or same sex is not at puberty. Instead, it is *before* puberty—at ten years, with a very wide age range of several years (Herdt, McClintock, Henderson, Lehavot, & Simoni, 2000). This "first attraction" might be merely hero-worship or a child's crush on a teacher but, on the other hand, it could be a real pre-echo of genuine attraction. Lombardo et al. do not explicitly give this as a rationale for testing at ages eight to eleven; however, the age of ten is conveniently covered by the age range they used.

Is it likely that better correlations may be achieved at puberty? We will have to wait and see, but in view of the existence of other influences that usually tend to reduce correlations rather than increase them, this is not likely. It is also possible that a testosterone/brain structure correlation like the one found by Lombardo et al. does not lead inevitably to a particular attraction (as in the case of the ferrets mentioned previously), so this is another reason the final association between fetal testosterone and attraction may be weaker than expected or may not exist at all.

Implications of the Modest Correlation with Fetal Testosterone

Some of the more extreme proponents in the research community may have expected to find an overwhelmingly strong testosterone/brain structure correlation, but it was actually surprisingly weak. It may be that other hormones are important and the focus of attention has been misplaced. This has important implications; although most research finds there is a correlation between fetal testosterone and later maleness, it does not *rigidly prescribe male brain structure but only modestly influences it.*

The important conclusion is this: *Heterosexual brain dimorphism seems only modestly prenatally prescribed by prenatal testosterone.* We now discuss two other independent lines of research that are consistent with that result.

Other Research Evidence for Modest Influence

The fetal/brain research gave a testosterone influence of 16 to 27%. There is very little other research that tries to estimate the quantitative strength of prenatal factors on heterosexual attraction, but one paper that did used twin studies (Hershberger, 1997). Although there is some slight doubt that testosterone in the womb is exactly the same even for identical twins, these studies are generally accepted. A weak to modest result (18 to 26%) for the influence of all prenatal factors on OSA was found. The sample was unmarried adults and was unusually favorable for testing heterosexual development. Calculations of the genetic influence on OSA from usual whole-population twin samples encounter intractable mathematical problems because relatively few respondents of minority sexual orientations are present; in an unmarried sample the percentage is much higher. Hershberger therefore was able to use this twin study to calculate the total prenatal influence on OSA.

This type of study is particularly important because twin studies test all prenatal factors combined, not just genetics or prenatal hormones. They include any effects of a theoretical later time in gestation when the brain might be preprogrammed independently of the earlier testosterone surge, as proposed by Diamond and others.

A result of this modest strength at the lower end of the range is similarly found when one investigates the wide spread of ages in first OSA attraction (Whitehead, submitted; see also Whitehead & Whitehead, 2010, p. 34). The wider the age spread in the appearance of any trait, the less likely it is to be genetic or biologically programmed, and the large spread for OSA makes the calculated degree of prenatal programming similar to the first two approaches—and a minor factor. These three similar results are shown in Figure 2.

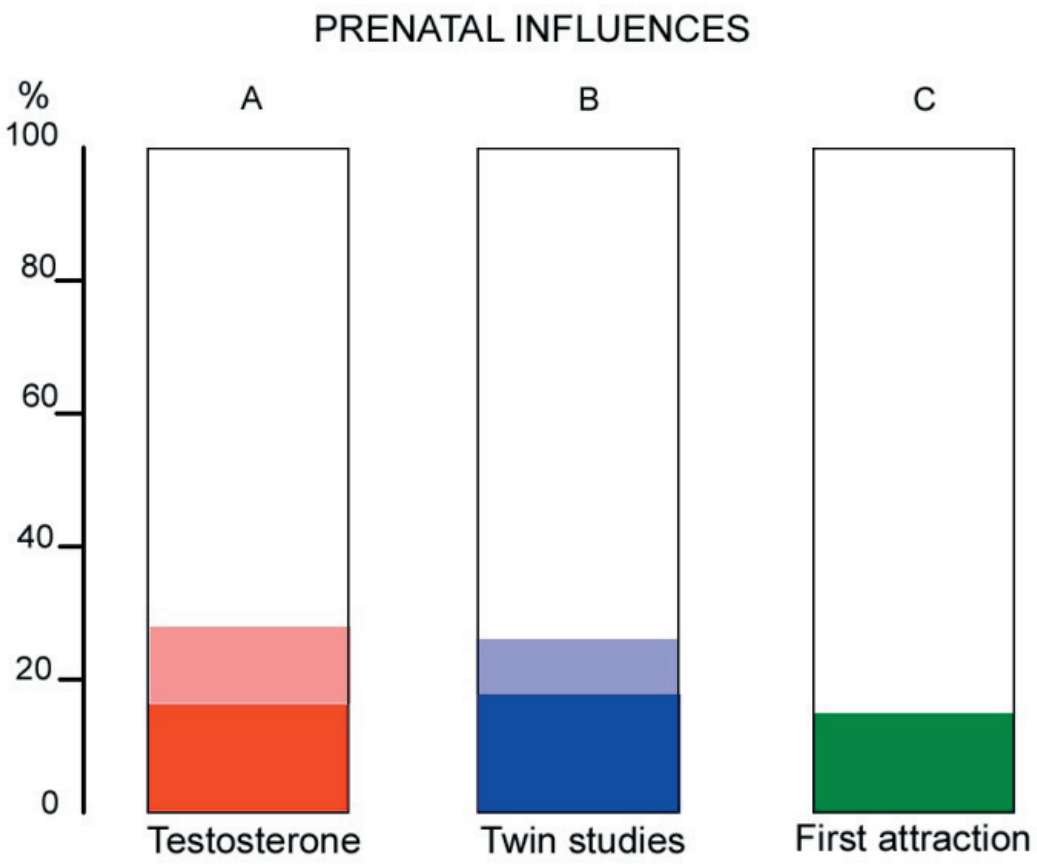

Figure 2.Percentage of prenatal influences on OSA as shown by (A) testosterone from amniocentesis, (B) twin studies, (C) age spread of first attraction. Shaded areas are 95% confidence limits where known.

The twin studies are the summation of all prenatal influences on adult sexual orientation. The testosterone results are only the influence of testosterone on sexually dimorphic brain structure, and are therefore more restricted. (For the purposes of this paper, it is assumed that adult sexual orientation is related to dimorphic brain structure, as the Phoenix et al. scheme proposes.) The similarity is important because of the hypothesis of Diamond (2009), mentioned earlier, that a prenatal influence independent of testosterone is important for sexually dimorphic brain structure. The similarity of A and B above means that the testosterone entirely accounts for the quite limited effects on the brain and that there is no room for another influence, as posited by Diamond.

We also note that the strength of the masculinizing influence for the CAS girls is 10 to 20%, consistent with the values discussed above. Studies on non-CAS girls from those born following amniocentesis would also be very useful in understanding female OSA, but the Hershberger twin studies indicate any prenatal influence on females is also weak to modest, as with the male results, and it is likely that the influence on female brain structure is similarly very modest.

What Does This Modest Effect Mean for Homosexual and Transgender Attraction?

The comparison of A and B in Figure 2 means that there is no room for a late-gestation influence on OSA. An unexpected corollary is that the transgender hypothesis of late gestational unusual brain programming—as proposed by Diamond (2009) and mentioned earlier—is not very likely. As shown in Figure 2, the late gestation period is not significantly involved in establishing OSA in humans and is therefore not likely to be involved in transgender origins either.

There is an independent implication in all this for the development of SSA, although only heterosexual orientation was examined in the Lombardo et al. paper. It has been popular to argue that SSA is prenatally programmed in humans and that the mechanism for males would probably be a lesser amount of testosterone at critical prenatal times. Such a mechanism, with its variable possible amounts of testosterone from slightly deficient to very deficient, would be expected to less tightly correlate with the final brain structure and therefore have an effect certainly not stronger than the effect on OSA, and more likely weaker. One therefore expects that the association between fetal testosterone and supposed SSA-related brain structure *should be less influenced by prenatal hormones than is OSA, so that the effect of prenatal hormones should be weak to modest, at best—not dominant.*

Other Factors in Sexual Orientation Development

For the first time, we have quantitative evidence about the strength of prenatal hormone influence on sexually dimorphic brain structure. This was expected by many to be overwhelmingly strong for humans, but instead it seems that testosterone is just one factor among several. Following is a list of some of the other influencing factors found in other research, but in all cases they are not individually predominant. The picture is therefore of many influences of modest strength working together on the brain—not just during fetal development but after birth through adolescence. Because the multiple factors may interact in many ways and could add or multiply their effects, accurate prediction of final sexual orientation based on these factors is at present too complex.

Research has increasingly revealed many other processes at work in the development of sexual orientation/attraction in humans. Since the time of the Phoenix et al. paper, researchers have discovered that there are some prenatal sexually dimorphic effects in the brain that depend directly on the sex chromosomes (Lenz, Nugent, & McCarthy, 2012), even where there is no influence of sex hormones and even in disorders of sexual development in which there are no gonads. Estrogen proves essential for feminization of the brain—females are not simply default males (Lenz et al., 2012). Testosterone masculinizes males, but there is also an independent process of defeminization (Lenz et al., 2012). There may be contribution from sex hormones produced in the placenta, and at birth there are high levels of sex hormones in the brain independent of circulating hormones and produced from cholesterol (Konkle & McCarthy, 2011). There is a male testosterone surge in humans just after birth that lasts much longer than the prenatal one; there is a corresponding estradiol surge for females (Winter, Hughes, Reyes, & Faiman, 1976). Some brain masculinization occurs *after* birth (Lenz et al., 2012). Sexually dimorphic human brain changes at puberty seem proportional to the sex hormone levels at that time (Neufang et al., 2009); this implies the importance of current hormone levels and not just prenatal influences. Further, since

maternal care significantly influences future sexual orientation, at least in rats (Moore, 1992), there is a general consensus that there are multiple influences at work rather than solely the prenatal testosterone surge.

This leads to a contemporary comment on the "organizational-activational hypothesis" Phoenix paper: "Our current knowledge of sex-based neurobiology has outgrown this simplistic model. Multiple lines of research have contributed to this conclusion" (Reinius, 2011, p. 15).

For therapists, this conclusion should reinforce the idea that therapy in the field of sexual orientation is a possible option. Such therapy will not encounter impassable barriers through brain structures already formed *in utero* that are, of course, unalterable.

The conclusion also has possible implications for parents. They cannot merely assume that heterosexuality will automatically develop in their children. As always, guidance and direction are a continuing part of parenting.

In a succeeding paper, the author hopes to discuss a further influence on brain structure—death of neurons in a sexually dimorphic way up to adulthood and unrelated results now available using gene expression measurements for the whole genome—to show the degree of sexual dimorphism in the brain at various ages. These support the interpretation in this paper.

Conclusion

The contribution of prenatal sex hormones to OSA or SSA is not anywhere near 100%, as many have believed, but is at most about 25%—in other words, a minor contribution. In that sense, one is not born straight or gay or transgender.

Simply stated, the prenatal hormonal contribution to heterosexual brain structure is weak to modest. Similarly, prenatal contribution to homosexual or transgender brain structure is weak to modest.

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Book Review of James E. Phelan's *Successful Outcomes of Sexual Orientation Change Efforts: An Annotated Bibliography*

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James E. Phelan has done a service to the profession in *Successful Outcomes of Sexual Orientation Change Efforts: An Annotated Bibliography.* As is evident from the title, in this short (130 pages) book Phelan has compiled research that documented positive outcomes in change-oriented psychotherapeutic intervention for unwanted same-sex attractions, behaviors, and identity. Relevant studies are grouped in separate chapters by therapeutic modality (psychodynamic, cognitive and behavioral, group, etc.) and are briefly outlined in chronological order. Of course, most of these studies were conducted during the heyday of such research—the fifties through the seventies—before cultural and professional changes declared such research entirely politically incorrect and therefore much more difficult to conduct and fund, despite today's more methodologically sophisticated designs. But this is one reason why it is important to have a compendium of this research available for scholars and those in the public who want to quickly familiarize themselves with this literature. The book's alphabetical bibliography section at the end also provides a handy reference for all source materials.

Beyond the value of documenting successful sexual orientation change efforts (SOCE) studies, I found it worth the read to realize that many studies, even in the mid-twentieth century, were defining success as occurring on a continuum of change as opposed to strictly categorical notions of SOCE—a definition NARTH (2012) has affirmed formally in recent years. Also worth the price of the book is Phelan's discussion of the factors associated with successful outcomes as well as the ethical issues involved in SOCE, including clients' right to self-determination of their treatment goals and modalities.

It should also be noted that Phelan apparently compiled his information as part of the process of coauthoring NARTH's response to the American Psychological Association's (APA) pre-2009 critiques of SOCE (Phelan, Whitehead, & Sutton, 2009). His annotated bibliography expands somewhat on details of the successful SOCE research presented in the NARTH response while sacrificing the broader contextual discussion that the NARTH report provides. Phelan acknowledges that his aim is to report only on successful SOCE literature. It is clear that he does not intend a thoroughgoing

critical review of these studies, nor does he intend to lay out the broader professional landscape that makes this successful SOCE literature important. For example, little comment is given to the fact that many studies define success in behavioral terms rather than as a change of sexual attractions.

Readers interested in the critique of this literature from a more skeptical perspective will have to look elsewhere, and I would recommend the APA's (2009) *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. The APA's report provides what could be viewed as a hypercritical stance, dismissing nearly all of the literature Phelan reviews on successful SOCE as equivocal at best, despite the fact that most of these studies met the acceptable professional and methodological standards of their era. While the APA's approach to the literature is transparently self-serving to those who understand their advocacy against SOCE, proponents of SOCE nevertheless would do well to know the arguments APA makes against such psychological care. To his credit, Phelan does offer a concluding chapter where he acknowledges that even the successful SOCE literature contains methodological limitations.

Perhaps the best summary statement Phelan makes of the successful SOCE literature occurs on page 95:

> Overall, the research literature is limited by sampling, assessment, and follow-up issues, however despite the methodological limitations of individual studies, there is nevertheless [a] compelling body of evidence that some individuals can shift identity and/or behavioral components of their sexual orientation after undergoing some type of intervention, or none at all.

This modest truth, testified to by a multitude of individuals across the globe, is what NARTH and others are diligently trying to preserve in a professional climate that often finds such statements inconvenient to certain advocacy goals. We can thank Phelan for making an important contribution to this effort.

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IFTC Written Intervention at OSCE/ODIHR 2013 Human Dimension Implementation Meeting, Warsaw, Poland

To: The Organization for Security and Co-operation in Europe (OSCE) Office of Democratic Institutions and Human Rights (OHIHR) Human Dimension Implementation Meeting (HDIM)

From: International Federation for Therapeutic Choice (IFTC)

Date: Tuesday, 24 September 2013: Working Session 3

Re: Tolerance and Nondiscrimination II

Legally Sanctioned Intolerance and Discrimination Threatens the Freedom of Medical and Mental health Professionals and Researchers to Provide—and Potential Patients or Clients to Receive—Freely Sought Education, Guidance, Therapy and Other Professional Care.

This intervention is being given on behalf of the International Federation for Therapeutic Choice (IFTC). The IFTC supports the rights of sexual minorities who have unwanted attractions, orientation, behavioral tendencies, behavior, and/or identity to

receive competent professional guidance and therapeutic care. The IFTC also supports the rights of medical and mental health professionals to offer that care (see www.therapeutic-choice.org).

Central Recommendation to Participating States of the OSCE:

To draft legislation to safeguard the freedom of:

1. Minor and adult persons to receive freely sought professional care in order to eliminate, diminish, or manage unwanted sexual minority feelings, behavior, and/or identity.

2. Medical and mental health practitioners, educators, and researchers to offer professional education, guidance, and therapy to minors (with the support of their parents) and adults who freely choose such care in order to eliminate, diminish, and/or manage any unwanted sexual minority feelings, behavior, and/or identity.

Some sexual minorities find their attractions, orientation, behavioral tendencies, behavior, and/or identity unwanted. Some of these people *freely choose* or have *freely chosen* to seek professional guidance and therapeutic assistance to avoid basing their relational and sexual lives according to their sexual minority attractions, behaviors, orientations, and/or identifications. More than one hundred years of clinical reports and other research literature document that some persons *have* been successful in achieving this goal *without* undo harm. Please refer to the first volume and the summary of the *Journal of Human Sexuality,* which reviews the clinical and scientific literature on this issue. (Both may be downloaded at http://narth.com/ 2013/02/journal-of-human-sexuality-volume-1-complete-text/)

Medical and mental health professionals who educate and offer guidance and therapeutic services to people with unwanted sexual minority concerns are experiencing an increasing amount of legally sanctioned intolerance and discrimination. Laws have recently been passed in the states of California and New Jersey (in the United States) that revoke the professional license of medical and mental health professionals who attempt to treat minors with unwanted sexual orientation, feelings, behaviors, and identities.

Such legislation and the ideological bias motivating it claim in effect that minors who receive such professional care—called "Sexual Orientation Change Efforts" (SOCE)—will be invariably and severely "harmed" in the process. As a result of that rationale, opponents claim, SOCE is considered intrinsically unethical and no medical or mental health professional may practice it ethically.

Such claims of harm are based on the ideologically biased and irresponsible use of scientific reports and professional opinions. If allowed by the courts to be enforced, such intolerance and discrimination not only will hinder professional practice, but will also hinder the freedom of minors (with the support of their parents) to receive health care, guidance, and education from these professionals—health care that the minors themselves and their parents have determined is necessary for the minors' health and well-being.

I offer some points for further clarification:

I. **Concerning California SB 1172:** On September 29, 2012, California governor Jerry Brown signed a law that had passed both houses of the California State Legislature. In its original form, the law proposed to prevent or significantly limit "mental health provider(s)" from engaging "in sexual orientation change efforts (SOCE)" with adults as well as with children (defined as persons under 18 years of age). But the bill that was signed into law limited the provision of services only to "a patient under 18 years of age." For the purpose of this law, "sexual orientation change efforts" are defined as any "efforts to change behaviors or

gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex."

- SB 1172 depended heavily on the 2009 *Report of the American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (http://www.apa.org/pi/lgbt/ resources/sexual-orientation.aspx). As its primary rationale, the law cites the 2009 *Report of The American Psychological Association* in which a task force on Appropriate Therapeutic Responses to Sexual Orientation concluded "that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people." In fact, the credibility for the harm is nonexistent. There is no objective evidence that any harm even occurred.

- In reality, the APA task force report actually concluded: "There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (*Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation,* www.apa.org/pi/lgbc/publications/, 83; cf. *The (Complete) Lack of a Scientific Basis for Banning Sexual-Orientation Change Efforts with Minors,* http://narth.com/2012/08/the-complete-lack-of-a-scientific-basis-for-banning/; *Fact-Checking California Senate Bill 1172* and *California Senate Bill 1172: A Scientific and Legislative Travesty,* both at http://narth.com/2012/05/california-senate-bill-1172-a-scientific-and-legislative-travesty/).

The 2009 APA task force report cited the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research in documenting the harm that may result from SOCE.

This research is methodologically inadequate as a basis for banning SOCE or any approach to medical or mental health care. For example, in the Shidlo and Schroeder research, there is *no* evidence *other than* the interviewees' claims

- that those who claimed to be harmed after participating in SOCE *actually participated* in any SOCE.

- that they *actually experienced* the harms they claimed to have experienced.

- That if they did undergo SOCE and experienced the harms they claimed, that the harms occurred *as a result of,* or even *during or after,* the sessions of SOCE.

- that all or even some of them did not experience any of the problems they report either *before* they began SOCE or *during or after* the SOCE *for reasons non-related* to the SOCE.

- *from whom* they received SOCE (for example, a therapist, pastor, or some other person). In this study, the professional status of the reported SOCE providers was not identified.

Schroeder, M., & Shidlo, A. (2002). Ethical issues in sexual orientation conversion therapies. In A. Shidlo, M. Schroeder, & J. Drescher (Eds.), *Sexual conversion therapy: Ethical, clinical and research perspectives* (pp. 131–166). New York: Haworth.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice,* 33, 249–259. doi: 10.1037//0735-7028.33.3.249.

- The APA and authors of CA SB 1172 ignored the clear caveat of the Shidlo and Schroeder authors about the limited generalizability of their study: *"The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy"* (Shidlo & Schroeder, 2002, 250; emphasis in the original). "Conversion therapy" is one of several generic names given to SOCE.

Christopher H. Rosik. (2012). Fact-Checking California Senate Bill 1172—Serious Inaccuracies and distortions abound: Are politicians willing to listen? Retrieved from http://narth.com/2012/05/ california-senate-bill-1172-a-scientific-and-legislative-travesty/

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Christopher H. Rosik. (2012). The (complete) lack of a scientific basis for banning sexual-orientation change efforts with minors: Claims by Sen. Lieu and SB 1172 of widespread harms to minors from SOCE represent rhetoric, not research. Retrieved from http://narth.com/2012/08/ the-complete-lack-of-a-scientific-basis-for-banning/

II. Concerning New Jersey AB 3371: On August 19, 2013, New Jersey governor Chris Christie signed into law AB 3371, which had previously been passed by both houses of the New Jersey State Legislature. Apparently learning from the experience with California's SB 1172, New Jersey AB 3371 was initially authored and subsequently passed only to prevent minors from receiving SOCE. Like the

California bill, this New Jersey bill cited as the best support for its claims for the harmfulness of SOCE a study that does not prove or show the harmfulness of SOCE.

- New Jersey AB 3371 cites a study by Ryan, Huebner, Diaz, and Sanchez (2009) in the respected journal *Pediatrics* as its best support for claims that SOCE in minors results in serious harm. It is evident that this study also contains many of the methodological limitations cited by the APA 2009 task force report that invalidates the scientific and professional literature supporting the efficacy of SOCE. In addition, like the Shidlo and Schroeder studies cited by the APA 2009 task force report and California's SB 1172, the Ryan et al. (2009) study itself has significant methodological difficulties. These difficulties include:

    - Participants were not blind to the study purposes.
    - Apparent biases were made in the participant recruitment process.
    - Reliance on self-report measures had participants recalling experiences from the distant past.

    Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics,* 123, 346–352. doi: 10.1542/peds.2007-3524.

- Generalization difficulties are also created by the sample composition of Ryan et al. (2009). The sample is limited to young-adult non-Latino and Latino LGB persons. The APA task force (2009) noted that research on SOCE has "limited applicability to non-Whites, youth, or women" (p. 33), and that "no investigations are of children and adolescents exclusively, although adolescents are included in a very few samples" (p. 33). This means that it is inappropriate

to even generalize their findings in a manner that would cast aspersions on all SOCE experiences of minors, which again is precisely what AB 3371 is determined to do. In addition, Ryan et al. (2009) acknowledge that "given the cross-sectional nature of this study, we caution against making cause-effect interpretations from these findings" (p. 351).

III. Professional efforts to sanction SOCE illustrate unethical scientific and professional negligence.

- Specifically, the APA has let SB 1172 declare uncorrected that the APA "task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people." The APA actually concluded, but has not corrected SB 1172 promoters, that: "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (*Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf), p. 83; cf. p. 67, 120).

- In general, in the 2009 APA task force report, the APA declared that therapist reports, as well as patient/client reports, showed that reports of patients/clients "benefitting" from SOCE were methodologically *unacceptable,* but that anecdotal reports of "harm" by alleged patients/clients *were* considered *acceptable.* These anecdotal reports were then used as evidence of harm. Other evidence of methodological and ideological biases have been reported as well.

James E. Phelan, Arthur Goldberg, and Christopher Doyle. (2012). A critical evaluation of the Report of the Task Force on Appropriate

Therapeutic Responses to Sexual Orientation, resolutions, and press release. *Journal of Human Sexuality,* 4, 41–69 (cf. http://narth.com/). Christopher H. Rosik. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* apply its research standards consistently? A preliminary examination. *Journal of Human Sexuality,* 4, 70–85 (cf. http://narth.com/).

- The framers of SB 1172 did not even cite their main source—the APA, one of the biggest foundations of their entire case—correctly. The negligence, if not fraud, cited above concerning the APA and "harm" is an example of unethical scientific-professional activism that is exhibited by all of the national mental health professions in North America.

- *Every* approach to medical and mental health care has the potential for harmful, or at least unwanted, side effects. And no approach is guaranteed to work for any particular patient or client, even if "taken or used as directed." Lambert (2013) reports that reviews "of the large body of psychotherapy research, whether it concerns broad summaries of the field of outcomes of specific disorders and specific disorders and specific treatments" lead to the conclusion that, while all clients do not report or show benefits, "psychotherapy has proven to be highly effective" (p. 176) for many clients. Unfortunately, research "literature on negative effects" also offers "substantial . . . evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192).

Lambert, M. (2013). The efficacy and effectiveness of psychotherapy. In Michael J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed.), pp. 169–218. Hoboken, NJ: Wiley.

- Yet, the APA persistently mentions the "potential for harm" *only* for sexual orientation change efforts (SOCE). On the other hand, Christopher Rosik, PhD, president of the National Association for Research and Therapy of Homosexuality, stated, "Anecdotal stories of harm are no basis from which to ban an entire form of psychological care. If they were, the psychological professions would be completely out of business."

- The APA is in violation of the first point in its own *Ethical Practices and Code of Conduct,* which states: "If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation" (Code of Conduct 1.01, Misuse of Psychologists' Work) (http://www.apa.org/ethics/code/principles.pdf).

These examples illustrate two recent incidents of ideologically biased and legally sanctioned intolerance and discrimination toward medical and mental health professionals and minor children and their parents who would choose to be patients or clients of the professionals.

Reports indicate that similar legislation is pending in three additional states in the United States, and the IFTC reported two years ago at this OSCE ODIHR previously in the 2011 HDIM about instances of professional intolerance and discrimination in the United Kingdom and Poland (http://www.osce.org/odihr/83505). Both past and recent

instances of legally sanctioned intolerance and discrimination violate a number of rights upheld by the Convention on the Rights of the Child (CRC) (http://files.meetup.com/3480872/Convention%20on%20the%20Rights%20of%20the%20Child%20.pdf). These include the right

- and responsibility that when adults make decisions that affect children, the best interests of children must be the primary concern (CRC, 3, 9, 18, 20, and 21).

- of families to be allowed to direct and guide their children so they can grow and reach their potential, and the responsibility of governments to support them in doing so (CRC, Preamble, 3, 5, 7, 9, 16, and 29).

- of children to procure and share information, form and express their opinions, and otherwise be involved in decision-making appropriate to their level of maturity, especially when adults are making decisions that affect the children's welfare (CRC, 12 and 13).

- of children to think and believe what they want and to practice their religion, and of parents to provide religious and moral guidance to their children (CRC, 2, 14, 29, and 30).

- of children to have access to information that is important to their health and well-being and the responsibility of governments to encourage mass media—radio, television, newspapers, and Internet content sources—to provide information that children can understand and to not promote materials that could harm children (CRC, 17, 19 and 23).

- of parents to provide appropriate guidance to their children, and the responsibility of governments to provide support services to parents in doing so (CRC, Preamble, 18).

- of children to an education that would develop their personality, talents, and abilities to the fullest (CRC, 18, 23, 28, and 29).

Such laws also violate a number of the rights upheld by the Universal Declaration of Human Rights (UDHR) (http://www.un.org/en/documents/udhr/ index.shtml#a11). These include the right of adults, as well as children, to

- freedom for the full development of one's human personality (UDHR, 26).

- medical care and necessary social services (UDHR, 25).

- freedom of thought, conscience, and religion (UDHR, 18).

- freedom of opinion and expression, which includes the freedom to hold opinions without interference and to seek, receive, and impart information and ideas through any media (UDHR, 19).

- the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation (UDHR, 12).

We therefore recommend to OSCE Participating States:

In light of the aforementioned fundamental rights upheld by the Convention on the Rights of the Child and the Universal Declaration of Human Rights:

1. To recognize and condemn intolerance and discrimination against sexual minorities who freely choose to receive help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity.

2. To draft legislation to safeguard the freedom of medical and mental health practitioners and educators to offer their professional guidance and therapeutic expertise to all people whose own sexual minority concerns are unwanted and who freely choose help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity. This includes minor children who themselves freely seek such services with the consent of their parents.

We recommend to OSCE/ODIHR and OSCE Missions:

1. To be aware of and condemn intolerance and discrimination against sexual minorities who freely choose help in order to eliminate, diminish, or manage unwanted feelings, thoughts, behavior, and/or identity.

2. To assist OSCE participating states in monitoring and drafting legislation, with special attention to safeguarding the above-mentioned rights upheld by the CRC and the UDHR.

The Alliance and NARTH Institute Response to the WMA Statement on Natural Variations of Human Sexuality[1]

Christopher Rosik

[1] Retrieved from and available at http://www.narth.com/#!world-medical-association---narth/c4c6. Please note that since it was originally published, the name of the National Association for Research and Therapy of Homosexuality (NARTH) has been either replaced in the title and the text by "the Alliance for Therapeutic Choice and Scientific Integrity (Alliance) and NARTH Institute" or had "Institute" added, as appropriate.

The Alliance for Therapeutic Choice and Scientific Integrity (Alliance) and NARTH Institute are greatly dismayed by the recent statement from the World Medical Association (WMA, 2013). The WMA statement is not so much a reflection on human sexuality as it is a clear attempt to discredit any and all professional attempts to assist clients who wish to modify same-sex attractions and behaviors. The Alliance and NARTH Institute observe that the WMA's statement in many places lacks scientific integrity, sometimes makes conclusions that are no more supportable than speculation, and at times fails to provide adequate scholarly context. Given these serious shortcomings, the Alliance and NARTH Institute believe it is necessary to provide the public with information that the WMA irresponsibly neglected in its statement.

The WMA states without equivocation that homosexuality is "without any intrinsically harmful health effects." This contention is exceedingly difficult to reconcile, for example, with a recent comprehensive review that found an overall 1.4% per-act probability of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer et al., 2012). These authors noted that "The 1.4% per-act probability is roughly 18-times greater than that which has been estimated for vaginal intercourse" (p. 5). In the United States in 2009, men having sex with men accounted for 61% of new HIV/AIDS diagnoses despite the fact that gay men are estimated to represent only 2–4% of the general population (Prejean et al., 2011; Savin-Williams & Ream, 2007). While such statistics may be influenced somewhat by stigma and discrimination, they appear to be ultimately grounded in biological reality. The Alliance and NARTH Institute are perplexed as to how the WMA could not consider such tragic medical effects as an intrinsic and harmful risk of male homosexual behavior.

While stigma and discrimination against gay and lesbian persons are important concerns with which mental health professionals ought to be concerned, the link between perceived discrimination and mental health outcomes is real, but the strength of this relationship is small (Pascoe & Richman, 2009). This means there is a great

deal more to be understood, and more moderating factors that may challenge current viewpoints need to be identified. For example, research into what influences the association between perceived discrimination and health outcomes has typically found no significant role for heretofore theoretically favored factors such as social support and identification with one's group. Similarly, constructs such as "internalized homophobia" may also be rapidly losing their explanatory utility (Newcomb & Mustanski, 2011). Findings also indicate that the incidence and type of psychological problems among gay and lesbian persons remains about the same whether they reside in tolerant and accepting environments or intolerant ones (Whitehead, 2010). This again suggests that our current understanding of the relationship between stigma and mental health outcomes may be far from definitive.

Worst of all, the WMA implies that professional psychological care to assist a client in modifying unwanted same-sex attractions and behaviors is a form of harm-inducing stigmatization and discrimination. The Alliance and NARTH Institute would kindly ask the WMA to provide the direct empirical basis for this supposition as well as a detailed list of the procedures NARTH Institute therapists engage in that allegedly exacerbate psychological distress. Since no study in existence disentangles preexisting client distress from any distress that may have occurred as a direct result of change-oriented psychological care, the Alliance and NARTH Institute believe the WMA statement in this regard has relied heavily on straw arguments. It certainly has not relied on the American Psychological Association's (2009) *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts* (SOCE), which had the honesty to acknowledge, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (p. 42). The WMA's clear dislike for a form of psychological care and its moral and theoretical assumptions, in the absence of definitive and replicated empirical evidence, is not a scientific basis for threatening medical and mental health professionals with "sanctions and penalties."

The WMA further fails to provide critical context for its unsubstantiated linking of change-oriented psychological care with psychological harm. Any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general. Extensive research has shown that 5–10% of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates—sometimes exceeding 20%—have been reported for children and adolescents in psychotherapy (Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013). Deterioration rates would need to be established for professionally conducted change-oriented therapy significantly beyond 10% for adults and 20% for youth in order for claims of approach-specific harms to be substantiated. The Alliance and NARTH Institute assume the WMA knows that prevalence rates of success and harm for change-oriented psychological care are currently unknown, so it is difficult to avoid the conclusion that the WMA is targeting such care on ideological and not scientific grounds.

Finally, as the Alliance and NARTH Institute find frequently in statements of activism, the WMA creates straw arguments by claiming practitioners such as those aligned with the NARTH Institute view their work as attempting to "cure" homosexuality—when, in fact, most recognize that change usually takes place on a continuum of change, as is the case for nearly every other psychological and behavioral condition for which people seek professional care. Furthermore, the WMA's attempt to invalidate the psychological care of unwanted same-sex attractions and behaviors on the grounds that homosexuality is no longer considered to be a psychopathology or illness betrays a profound misrepresentation of the scope of psychotherapeutic practice. There are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy.

The experience of NARTH Institute clinicians is that, overwhelmingly, clients seek out their services due to moral and religious concerns, not because they consider

same-sex attractions and behaviors as a disease or psychopathology. In fact, clients pursue psychological care for many difficulties due to deeply held religious and moral beliefs (such as those stating that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention the WMA gives to change-oriented psychological care again hints at ideology rather than science as a primary motivation behind its statement.

The Alliance and NARTH Institute consider the WMA's recommendations to be an unacceptable encouragement of legislative or other intolerance and discrimination against sexual minorities who freely choose to receive help in order to overcome or diminish their unwanted sexual attractions, behaviors, and/or identity. This includes youth who themselves freely seek such services with the consent of their parents. Legislative or other intolerance and discrimination against medical and mental health practitioners, educators, and researchers is similarly unacceptable. The WMA would seek to prevent these professionals from offering their expertise to persons whose sexual minority concerns are unwanted and who, after being provided with informed consent, freely choose help in order to resolve, diminish, or manage them.

If enacted in any national or international jurisdiction, organizational intolerance and discrimination such as that recommended by the WMA would be a violation of human rights as recognized by the Universal Declaration of Human Rights (UDHR) (http://www.un.org/en/documents/udhr/index.shtml#a11) and the Convention on the Rights of the Child (CRC) (http://files.meetup.com/3480872/Convention%20on%20the%20Rights%20of%20the%20Child%20.pdf). These include the rights of both adults and children to: (1) the full development of one's human personality (UDHR, 26; cf., CRC, Preamble, 18 and 29); (2) medical care and necessary social services (UDHR, 25; cf. CRC, Preamble, 24, 27, and 39); (3) freedom of thought, conscience, and religion (UDHR, 18; cf., CRC, 14, 30); (4) education and freedom of opinion and expression, which includes the freedom to hold opinions without interference and to seek, receive,

and impart information and ideas through any responsible media (UDHR, 19; cf., CRC, 12, 13, and 17); and (5) the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation (UDHR, 12; cf., CRC, Preamble, 3, 5, 16, 29, 34, and 36).

These are but a few of the concerns that the Alliance and NARTH Institute have with the WMA statement, but they should be sufficient to illustrate the statement's deeply flawed and misleading portrayal of change-oriented psychological care. Additional relevant information can be obtained at the Alliance website (www.therapeuticchoice.com) and in the latest issue of the *Journal of Human Sexuality* (e.g., Rosik, 2013).

The Alliance and NARTH Institute believe the proper course of action for a truly professional organization given the current limited scientific base of knowledge regarding change-oriented psychological care should be to encourage further and ideologically diverse research. Instead, the WMA statement would infringe upon the rights and freedom of therapists and their clients with unwanted same-sex attractions and behaviors by creating a strict orthopraxy that is not grounded in definitive or properly contextualized empirical data. Within this orthopraxy, the WMA refuses to give its imprimatur to certain moral, religious, and theoretical views of homosexuality. It also restricts the range of options available for how clients with unwanted same-sex attractions and behaviors can therapeutically address their conflicts. The WMA statement thus appears to represent the rhetoric of heavy-handed activism and intimidation and is beneath the dignity of an organization that claims a professional and scientific identity.

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What Research Does and Does Not Say about the Possibility of Experiencing "Harm" by Persons Who Receive Therapeutic Support for Unwanted Same-Sex Attractions or "Sexual Orientation Change Efforts (SOCE)"[1]

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[1] A version of this document was published in February, 2014 by Core Issues Trust. Retrieved from http://www.core-issues.org/uploads/IFTC%20Sutton%20Paper%2021%20Feb%202014.pdf. A version of this document also has been accepted for publication by *Linacre Quarterly.*

Abstract

In recent years, national and international medical and mental health associations typically have emphasized the potential harmfulness of professional care for unwanted same-sex attraction and behavior (SSA or homosexuality). During 2012 and 2013, state legislatures in the U.S. and legislative bodies in other countries either have passed or are considering passing laws which would penalize professionals who provide professional care for unwanted SSA—to minors and/or adults—with the loss of license to practice. This paper was written as a response to the present situation in the United Kingdom. The paper reviews the universal ethics of all medical and mental health professionals to avoid harm and do good (nonmaleficence/malfeasance and beneficence); discusses the documented potential for harm when using *every* mental health treatment for *every* presenting problem; clarifies steps taken by the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) and its international division, the International Federation for Therapeutic Choice (IFTC), to promote ethical professional care for unwanted SSA; clarifies the injustice and presumed ideological biases of the medical and mental health associations' warning about the potential for harm for psychotherapy only for unwanted SSA and not all approaches; and documents that the research purporting to show this harmfulness, in the research authors' own words, does not do so. Recommendations to promote scientific integrity in the conduct and reporting of relevant research are offered.

Introduction

It has come to the attention of the International Federation for Therapeutic Choice (IFTC) that the UK Parliament will soon be debating the merits of the proposed Private Member's Bill Counsellors and Psychotherapists (Regulation) Bill no. 14120 (http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0120/14120.pdf), which would amend Section 60 of the Health Act 1999 (Regulation of health care and associated professions) as follows: "The [*Code of ethics for registered counsellors, therapists and psychotherapists]* must include a prohibition on gay to straight conversion therapy." The *Complaints and disciplinary procedures of the Code* would be amended as follows: "(2) A practitioner found by the Council to have breached . . . that section of the code relating to prohibition of gay to straight conversion therapy shall result in permanent removal from the register."

This information came to our attention when reading a professional statement by the United Kingdom's Association of Christian Counsellors (ACC, 2014) and a news report of this statement in *The Guardian* (Strudwick, 13 January 2014). Both the ACC statement and *Guardian* report made serious allegations about the great risk for "harm" to persons who receive "reparative or conversion therapy," what the American Psychological Association (APA) has chosen to call "Sexual Orientation Change Efforts (SOCE)" (APA, 2009).

Members of the IFTC (www.therapeutic-choice.org/) and the IFTC's parent organization, the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI; www.therapeuticchoice.com), and like-minded licensed medical and mental health professionals refer to such therapy as licensed professional care to "change"—i.e., manage, diminish, or resolve—unwanted same-sex attractions (SSA) and behavior. Such professional care may include educational guidance, counseling, therapy, and/or medical services.

Specifically, the ACC statement declared: "We do not endorse Reparative or Conversion Therapy" because of "the potential to create harm" and "in the interests of public safety." The report in *The Guardian* commented:

> Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder . . . found 'conversion therapy' *usually* led to worsened mental health, self-harm and suicide attempts . . . such treatment *routinely* led to worsened (sic) self-harm, thoughts of suicide and suicide attempts (emphasis added). [2]

The ACC statement and *Guardian* story reflect the views of four leading mental and medical health professional associations in the UK. The British Medical Association (2010) voted at its Annual Representative Meeting that "'conversion therapy' for homosexuality . . . is discredited and harmful to those 'treated'." The British Association for Counselling and Psychotherapy (2013) mentions the PAHO/WHO (2012) position statement that practices "such as conversion or reparative therapies . . . represent a severe threat to the health and human rights of the affected persons" (p. i).

Similarly, the Royal College of Psychiatrists (n.d.) states that "we know from historical evidence that treatments to change sexual orientation that were common in the 1960s and 1970s were very damaging" and specifically mentions that the 2002 "Shidlow [sic] and Schroeder" study showed that such treatment resulted in "considerable harm." And the UK Council for Psychotherapy (2010) asserts that a person who undergoes "therapy that aims to change or reduce same sex attraction" is at risk for "considerable emotional and psychological cost" (p. 3).

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[2] This report was retrieved on 15 January 2014. When attempting to retrieve this report again on 6 February 2014, the link no longer worked. Instead, a report by the same name was retrieved from http://www.theguardian.com/world/2014/jan/13/christian-therapists-stop-conversion-therapy-turn-gay-patients-straight. In this revised *Guardian* report, the claims of "harm" due to "conversion therapy" are described as follows: "Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder has shown such treatment routinely led to worsened mental health, self-harm, thoughts of suicide and suicide attempts."

These and other recent allegations that the harmfulness of "SOCE" has been proven scientifically are simply false (Rosik, 2013a, 2013b, 2013c, 2013d, 2013e). Warnings by national mental health associations of the "potential harmfulness of 'SOCE'" are unscientific, professionally irresponsible, and misleading, if not dishonest.[3] These observations are explained below.

1. First, *do no harm*. Then *do as much good as you can*. Avoiding and minimizing harm (nonmaleficence, nonmalfeasance) and doing good for those one serves (beneficence) are the foundational principles of ethical care by all mental—and medical—health care professionals. As an illustration, the first Principle of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010) states:

> *Principle A: Beneficence and Nonmaleficence:* Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons

2. *Every* approach to medical and mental health care has the potential for harmful—or at least unwanted—side effects. And no approach is guaranteed to work for any particular patient or client, even if "taken or used as directed."

Lambert (2013) reports that reviews "of the large body of psychotherapy research, whether it concerns broad summaries of the field or outcomes of specific disorders and

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[3] The IFTC (2011, 2012, 2013) has offered interventions at the Organization for Security and Co-operation in Europe (OSCE) Office of Democratic Institutions and Human Rights (ODIHR) Human Dimension Implementation Meeting (HDIM) in Warsaw, Poland, on these and related concerns.

specific treatments" lead to the conclusion that, while all clients do not report or show benefits, "psychotherapy has proven to be highly effective" for many clients (p. 176). Unfortunately, the research "literature on negative effects" also offers "substantial . . . evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192). Such findings have been reported in the therapeutic and scientific communities for over three decades (Lambert, 2013; Lambert & Ogles, 2004; Lambert & Bergin, 1994; Lambert, Bergin & Collins, 1977; Lambert, Shapiro & Bergin, 1986; Nelson, Warren, Gleave, & Burlingame, 2013; Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010).

As Rosik (2013c) has written,

> Any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general. . . . Deterioration rates would need to be established for professionally conducted change-oriented therapy ("SOCE") significantly beyond 10% for adults and 20% for youth in order for claims of approach-specific harms to be substantiated.

In this light, it is unfortunate that the UK Association of Christian Counsellors (2014) has the following ethical guideline for membership: *5.5. "Members should avoid any action which might cause harm to a client."* If any—and every—action that *may* occur in counseling "*might* cause harm to a client," how does the ACC envision any of its counselors ever attempting to serve their clients? Their position is not science but wishful thinking. As Rosik (2013e) has noted:

> Reasonable clinicians and mental-health association representatives should agree that anecdotal accounts of harm constitute no basis upon

> which to prohibit a form of psychological care. If this were not the case, the practice of any form of psychotherapy could place the practitioner at risk of regulatory discipline, as research indicates that 5 to 10% of all psychotherapy clients report deterioration and as many as 50% experience no reliable change during treatment. (p. 109)

3. The IFTC and ATCSI have taken steps to minimize the potential harmfulness and enhance the potential helpfulness of professional care for unwanted SSA through the Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior (NARTH, 2010). (See Appendix A—below—for the short form of the Practice Guidelines.)

These Practice Guidelines were formally adopted in 2008 and published in 2010. Their purpose is to guide the ethical practice of "change-oriented" professional mental health care for unwanted SSA. The Practice Guidelines have been written, published, and used to educate medical and mental health professionals—as well as concerned nonprofessionals—about how to enhance the helpfulness and avoid any harmfulness of providing professional care for unwanted SSA.

For example, Practice Guideline 5 advises: *"At the outset of treatment, clinicians are encouraged to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent."*

Concerning potential harmfulness, Practice Guideline 6 states: "Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions."

As many of the "therapists" who reportedly provided "conversion therapy" to persons interviewed by Shidlo and Schroeder (2002) were not professionally trained or licensed (see Point 5 below), Practice Guideline 11 is especially relevant: "*Clinicians*

are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area."

Translations of the short form of the Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior are available, so far, in Chinese, French, German, Italian, Polish, Russian, and Spanish. Translations of the long form are available in Polish and Spanish as well. These translations may be retrieved from http://www.narth.com/#!about3/c1k2y

4. "***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***" (American Psychological Association, 2009, p. 83). In the same document, the APA states further: "None of the recent research . . . meets methodological standards that permit conclusions regarding efficacy or safety (APA, 2009, p. 2.) The APA similarly emphasizes that "recent SOCE research cannot provide conclusions regarding efficacy or safety" (p. 3). The APA offered these conclusions *after* having reviewed all relevant research to date, including the study by Shidlo and Schroeder (2002).

5. In the authors' own words, the Shidlo and Schroeder (2002) study does "*not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (p. 249), i.e., "SOCE."

Shidlo and Schroeder acknowledge that *how* they conducted their study limits what any reports of "harm" given by the participants in their study may mean**.** The authors accurately describe their research as an "exploratory study . . . based on the retrospective accounts of consumers" who are asked to talk about what their therapists did and what the consumers experienced "on average. . . . 12 years ago" (p. 250). The authors acknowledge that, like all research using this method, the reports of the alleged consumers' perspectives on their experience of therapy "may not accurately reflect"

what actually happened. Shidlo and Schroeder discuss the potential limitations of the accuracy of the reports of their consumers, in light of the earlier findings of Rhodes, Hill, Thompson, and Elliott (1994) that "retrospective data from clients" are subject to "misunderstandings" about what happened years earlier in psychotherapy. As actual former clients try to make sense of the events of their experience of therapy, they may unknowingly change the details of their story (Rhodes et al., p. 481).

Additional problems with how the Shidlo and Schroeder study was conducted further erode the scientific credibility and significance of any of its results.

- Initial participants of the study were recruited with the following advertisement:

> Have you gone through counseling or therapy where you were encouraged to become heterosexual or ex-gay? The National Lesbian and Gay Health Association wants to hear from you. The organization is conducting research for a project entitled "Homophobic Therapies: Documenting the Damage." (Shidlo & Schroeder, 2002, Appendix A)

Such a recruitment statement is an example of research based more on ideology than on objective, scientific inquiry.

- There is *no* evidence—*besides* the interviewees' claims—that

  - They *actually participated* in a "conversion therapy" ("SOCE").
  - They a*ctually experienced* the harms they claimed to have.
  - Any actual harm did not preexist their experience of "conversion therapy" ("SOCE").

  - Any actual harm occurred *as a result of*, *during* or *after*, the sessions of "SOCE," instead of as a result of an experience outside of "therapy."

- While approximately two-thirds of the "therapists" reported by the presumed former clients were described as "licensed mental health practitioners," one third of the "therapists" were "unlicensed counselors," including "peer counselors, religious counselors, and unlicensed therapists." Shidlo and Schroeder did not clarify what kinds of "harm" were associated with which kind of therapist. This study does not—and cannot based on how it was designed and conducted—show that, if consumers were harmed, this resulted from the actions of licensed mental health professionals who provided "conversion therapy" (i.e., professional "SOCE") versus nonprofessional caregivers.

- Ironically, a careful reading of the report of this study, which admittedly was intended to "document the harm" experienced by consumers of "SOCE," also showed the opposite result. In particular, the results suggest that preexisting suicidality was at least managed, not induced by the participants' experience of "SOCE" (Whitehead, 2010, pp. 161–165).

- Several studies published during the past two years that were also intended to document the harm of receiving such professional care suffer from the same methodological difficulties as the Shidlo and Schroeder (2002) study and offer no better evidence in support of the harmfulness claim (Rosik, 2014).

6. Medical and mental health professionals, and their patients and clients, would not allow the kind of "evidence" provided by the Shidlo and Schroeder (2002) study to prevent them from receiving wanted treatment for any other concern.

Imagine how someone who has experienced a helpful medical or mental health-care product or service would feel if their product or service were forbidden them based on the kind of information provided by the Shidlo and Schroeder (2002) study. Otherwise satisfied customers would be refused the chance to continue—and willing new consumers to start—receiving these products for services based on complaints—but no clear evidence—of harmful side effects. Those complaining would not have to prove that they actually received the products or treatment—or that they had used them as directed. The complainers would not have to prove that they actually experienced the side effects they claimed or that the side effects did not already exist prior to their treatment. Nor would complainers have to prove who they received the product or service from, while admitting that some of the care providers were professionally licensed, but as many as a third were not.

Most people would not accept their favorite pain reliever or medical treatment being taken off the market based on such minimal "evidence." Retrospective ("anecdotal") reports—based on what allegedly happened an average of 12 years ago—are not an acceptable standard of "evidence" for stopping or preventing others from receiving care which *has* been found helpful by some. The various professional organizations which are so quick to accept the truthfulness of any complaints about the harmfulness of "SOCE" are also too quick to deny the validity of over a century of professional reports which document wanted changes in same-sex attraction and behavior (APA, 2009; NARTH, 2009; Phelan, 2014).

As a rule, IFTC, ATCSI, and allied mental health professionals do *not* attempt to "cure" same-sex attractions and behaviors. Rather, we agree that change in sexual orientation is not typically categorical in nature and observe that clients may experience changes on a continuum that is personally meaningful and satisfying (NARTH, 2012). While not agreeing that "SOCE" is or may be beneficial, even the APA (2009) admits that "the recent research on sexual orientation identity diversity illustrates that sexual

behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid" (p. 14, cf. p. 2). Fluidity in sexuality, sexual orientation, sexual orientation identity, and relationships—without professional assistance—seems especially true among adolescents (p. 76) and women (p. 63; cf. Diamond, 2009), and has been documented as occurring among men as well (Laumann et al., 1994).

7. There is a violation of some clients' right to "self-determination" and a potential for harm, for *not* offering—let alone forbidding—professional care for unwanted SSA ("SOCE") to persons who freely choose to seek such care.

Another foundation for ethical, beneficial practice is respect for clients' and patients' right to "self-determination." As Principle E: Respect for People's Rights and Dignity of the APA (2010) Ethical Principles states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and *self-determination*" (emphasis added). Surely this must include the rights of persons to choose to manage or resolve same-sex attractions and behaviors.

Also, there would be appear to be the potential for grave harm caused to some people by neglecting to provide such care for those who want it. There are significant medical and psychological health risks which co-occur with engaging in same-sex behavior (CDC, 2014; NARTH, 2009, III. Response to APA Claim: There Is No Greater Pathology in the Homosexual Population Than in the General Population, p. 53–87; Whitehead, 2010).

Anecdotal and correlational studies clearly document that sexual abuse and other emotionally traumatic events are more common in the childhoods of persons with sexual minority attractions and behaviors than those with heterosexual (Austin et al., 2008; Corliss, Cochran, & Mays, 2002; Friedman et al., 2011; Lehavot, Molina, & Simoni, 2012; Stoddard, Dibble, & Fineman, 2009; Steed & Templer, 2010; Tomeo, Templer, Anderson, & Kotler, 2001; Wells, Magnus, McGee, & Beautrais, 2011). Sexual abuse in

particular has been shown to precede the development of gender nonconformity (Alanko, et al., 2008; Roberts, Glymour, & Koenen, 2103) as well as of same-sex attractions and behavior for some persons (Fields, Malebranche, & Feist-Price, 2008; Walker, Archer, & Davies, 2005).

While further research is needed to clarify the extent of any causal connection between traumatic childhood events and the development of SSA and behavior, their co-occurrence is undeniable. Professional compassion warrants assisting those who want to try to manage and resolve SSA behaviors—and the underlying feelings and experiences which may motivate them.

8. **Moving forward, it is necessary that national and world medical and mental health associations deal with the issue of therapeutic choice concerning unwanted same-sex attraction in a professionally responsible manner with scientific integrity.**

Persistent warnings that professional "SOCE" have "the potential to harm" those who receive them are misleading and disserve the general public. Organizations like the American Psychological Association, the World Medical Association, and—most recently—the Association of Christian Counsellors in the UK, in effect deceive the public when they—not inaccurately—warn that there is a *potential* for harm but then do not qualify this warning by clarifying that (1) *all* mental health services for all personal and interpersonal concerns have this risk *and* (2) that responsible science has not yet shown whether the degree of risk for professional "SOCE" is greater, the same as, or less than the risk for all other psychotherapies.

Overall, we agree with Shidlo and Schroeder (2002) that more "c*omplementary research* [is] *needed."* Such research ideally *"would include interviews with sexual orientation conversion therapists and analysis of psychotherapy sessions by independent third-party observers.*" In the absence of such clear, reliable, and valid scientific evidence, it is difficult to avoid the conclusion that professional organizations like the American

Psychological Association, the UK Association of Christian Counsellors, various state and national government legislatures, and even media such as *The Guardian*, are working to prevent mental health professionals from offering educational guidance, counseling, and therapeutic care for persons with unwanted same-sex attraction and behavior based on ideological and not scientific or professional grounds. Persons who experience unwanted same-sex attractions and behaviors deserve the right to receive professional care to try to change (i.e., manage, diminish, or resolve) these feelings and actions if they choose to do so.

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Appendix A

Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behaviors

In December 2008, at its annual strategic planning meeting, the National Association for Research and Therapy of Homosexuality (NARTH)'s board of directors formally accepted the following Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behaviors. Their purpose is to educate and guide mental health professionals who affirm the right of clients to pursue change of unwanted same-sex (homosexual) attraction and behavior (SSA), so that these professionals may provide competent, ethical, and effective guidance and care to those who seek it.

The goals of the Practice Guidelines are twofold: (1) to promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who seek change-oriented intervention for unwanted same-sex attractions and behavior, and (2) to provide information that corrects stereotypes or mischaracterizations of change-oriented intervention and those who seek it. These guidelines reflect the state-of-the-art in the practice of guidance and psychotherapy with same-sex-attracted clients who want to decrease homosexual functioning and/or increase heterosexual functioning.

NARTH's Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior

Attitudes Toward Clients Who Seek Change

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

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

Guideline 3. ***Clinicians are encouraged to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing change-oriented interventions.***

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

Treatment Considerations

Guideline 5. ***At the outset of treatment, clinicians are encouraged to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent.***

Guideline 6. ***Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.***

Guideline 7. ***Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions that often accompany same-sex attractions and to offer or refer clients for relevant treatment services to help clients manage these issues.***

Guideline 8. ***Clinicians are encouraged to consider and understand the difficult pressures from culture, religion, and family that are confronted by clients with unwanted same-sex attractions.***

Guideline 9. ***Clinicians are encouraged to recognize the special difficulties and risks that exist for youth who experience same-sex attractions.***

Education

Guideline 10. ***Clinicians are encouraged to make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religious resources that can support clients in their pursuit of change.***

Guideline 11. ***Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area.***

As do all professional guidelines, the preceding Practice Guidelines were written in order to supplement accepted principles of psychotherapy, not to replace them. As *guidelines*, they are aspirational and intended to facilitate the continued, systematic development of the profession and to help assure a high level of professional practice by clinicians. The clinical and scientific research which supports each of the Practice Guidelines is explained in detail in Volume 2 of NARTH's *Journal of Human Sexuality* (*JHS*). A copy of *JHS* Volume 2 may be retrieved from http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2 and the complete Practice Guidelines may be retrieved from http://www.scribd.com/doc/ 115508811/NARTH-Practice-Guidelines. Translations of the short form of the Practice Guidelines (Guidelines only without explanation) are available, so far, in Chinese, French, German, Italian, Polish, Russian, and Spanish. These translations may be retrieved from http://www.narth.com/#!about3/c1k2y