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Editor's Comments

Certainly the year 2020 will be remembered as a time of adjustment and appreciation. Adjusting to limited opportunities for in-person conversations and professional conferences and renewed appreciation for the written word and the importance of publications like this, the 11th edition of the *Journal of Human Sexuality*.

Again this year we express our sincere appreciation to Christopher Rosik, PhD, for his meticulous and dedicated stewardship as the Editor of the *JHS*. This edition offers a lineup of papers, case studies, literature, and book reviews. All of these reflect our commitment to the responsible conduct, dissemination, and use of science by professionals, public policymakers, legislators, and other non-mental health professionals involved in promoting medical and mental health on both a personal and public level. Authors of *JHS* articles and reviews are held to the criteria; what is written needs to be based on a fair reading and the responsible reporting of scientific data and demonstrable professional experience.

The Alliance for Therapeutic Choice and Scientific Integrity is a multi-disciplinary educational, 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 attractions. The Alliance launched the *Journal of Human Sexuality (JHS)* in 2009 to serve its mission and as a way of presenting, encouraging, and producing quality clinical and scientific scholarship on topics related to various aspects of sexual minority issues and on human sexuality in general.

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

David Clarke Pruden, M.S.
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Working with Members of The Church of Jesus Christ of Latter-day Saints Who Struggle with Unwanted Same-Sex Attractions and Behaviors

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Members of the Church of Jesus Christ of Latter-day Saints (commonly known as Mormons or Latter-day Saints) believe in the tenants of most other Christian congregations, including the basic principles as expressed in the Bible along with other unique scriptures and prophetic revelations. They believe God exists, He is aware of them and their trials, and He will support them in their desire to live in concert with their life-

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encompassing gospel plan of salvation. Members of the LDS Church believe they lived in a premortal existence, as gendered spirit children of heavenly parents. However, it is generally difficult for a member of the Church to share their personal feelings and/or deeply held values, their perceived sexual attractions, or gender identity issues. This article provides the clinically trained therapist with sufficient basic information regarding their LDS client's believed eternal identity, cultural environment, and worldview, to enable them to initiate a therapeutic alliance and maintain a foundation of hope for the future.

Keywords: Unwanted same-sex attraction, Church of Jesus Christ, psychotherapy, premortal existence

When presented with the opportunity to work with a new client, the therapist is responsible from the very first meeting for building rapport with him or her, through professional empathic listening, caring, and warmth. The quality of this connection between therapist and client is one of the most consistent predictors of successful treatment. When the relationship is a good fit and the client feels he or she can trust the therapist to handle their presented mental health issues with care and without prejudice, therapy can prove to be a solid foundation upon which the client can risk sharing fears and desires, as well as hopes for the future.

This process of trust-building and the resulting therapeutic connection begins with the initial intake and assessment conversation as the therapist demonstrates their respect and concern by listening intently and asking relevant open-ended questions regarding the client's background, values, and concerns. During this detailed and professional exploration of the issues of concern for the client, both the client and the therapist begin to develop an awareness of the nature of the presenting problem and the cultural individual and family environment from which it stems.

Critical to the skilled initial assessment process, as aptly posed by Brammer et al. (1989) is the attempt to answer several key questions:

> What are the client's presenting problems? How do these problems fit into a comprehensive picture of client functioning? How does the client's unique history influence his or her experience of and manner of dealing with the problem? Does the client's problem have a function in the larger systemic context? What is the therapist's experience of the client and his or her interpersonal style?

In pursuit of these questions, effective clinicians go beyond their client's presenting concerns, or reason for referral, as they evaluate background issues pertaining to work, school, or other major life roles such as social and personal-emotional adjustment, all the while observing the in-session non-verbal responses of their clients. Clinicians examine developmental and family history, including current and past family and parental relationships, religious and faith beliefs, and previous peer and social experiences. The therapist also enquires about medical and psychiatric conditions, including possible substance abuse and any attempted suicidal ideation, and they may also collect and review formal psychological assessment data. This lengthy case conceptualization process supports the counselor's ongoing and deepening understanding of the client's needs and challenges and is therapeutic in its ability to nurture the counseling relationship between the client and counselor (Whilston, 2009).

Because a client's ability to connect with their therapist often rests upon the client's ability to sense the therapist's unconditional positive regard, some clients will request to work with a therapist who shares similar life experience or comes from a similar culture or

background. Other clients will say they don't care about the race, culture, gender, or background of their therapist, as long as he or she is competent to help clients deal with their presenting mental health issues. Still other clients may come from a background, or live in locations, where finding a therapist with a similar cultural history is almost impossible. However, despite a client's initial beliefs regarding with whom they, as a new presenting client, can share the intimate personal details of their mental health status, the therapeutic process will ultimately rest upon the therapist's ability to understand, respect, and appreciate their client's background and closely held values. In essence, this intake process gives the therapist a view of their client's belief about what is important in life.

Critical to the therapist's ability to understand and appreciate the reality of their client's current situation is the therapist's ability to compare and contrast what their client perceives to be the case, with the therapist's perceptions of their client's true and lived reality. This is especially important when any client who self-identifies as a member of The Church of Jesus Christ of Latter-day Saints (also known as the "Mormon" or the Latter-Day Saint Church) seeks assistance through counseling, to remediate or resolve a conflict between the their unwanted same-sex attractions or perceived gender dysphoria. Because of the deep stress and ego dystonic social-emotional conflict involved in coping with life in a very liberal society and, at the same time, being reared from childhood in a very conservative Church culture, troubled members of the LDS Church who present for counseling are often unaware of the depth of their conflicting sexual feelings and attractions. The LDS client will either believe they can process their presenting emotional difficulties quickly and/or superficially or will believe "there is very little any therapist can do" to help them remediate their emotional struggle and pain, but "at least they have to give 'therapy' a try." Whatever the presenting attitude, the LDS client will not understand the potential difficulty of communicating with a therapist when confronted with the need to verbalize and to discuss very intense and unwanted sexual feelings, attractions, and/or compulsions.

For an LDS client, any meaningful communication with a therapist can only occur within the understanding of their cultural environment and the language of their spiritual lives and believed eternal identities. This does not mean the LDS client will need to discuss their personal concerns only with a member of the Church, but it does mean that a non-Latter-day Saint professional counselor must be aware of the LDS client's need to be accepted and heard by someone who respects "who the client is," "where he or she wants to go in this life," and "where the client expects (or hopes) to go" after this life. Ultimately, the client will need to connect with the unconditional positive regard of the therapist and trust they will be understood because of (or despite) their inculcated values and beliefs.

As a foundation, a therapist can rightly assume that given the name of The Church of Jesus Christ of Latter-day Saints, its members will have a basic acceptance of Christian values and a strong belief in the Bible, as is the case with faithful Roman Catholic or Evangelical Christian clients, as reported in two articles of the previous volume of this journal, by Dr. Philip M. Sutton, "Serving Persons with (Unwanted) Same-Sex Attraction and Behavior (SSA) from the Roman Catholic Tradition" (Sutton, 2019) and Drs. Julie H. Hamilton and Philip J. Henry, "Working with Evangelical Christian Clients Who Have Unwanted Same-Sex Attractions" (Hamilton & Henry, 2019).

In addition to many shared doctrinal beliefs concerning sex and gender, a therapist

or counselor should be aware of unique Latter-day Saint theological perspectives that constitute a major part of their client's unique worldview. These religious concepts are integral to the understanding a Latter-day Saint has regarding the essential purpose of mortal life and his or her future in eternity. The following quotation from Elder Dallin H. Oaks, a member of the current First Presidency of the Church, will frame three of these doctrinal beliefs:

> The purpose of mortal life and the mission of The Church of Jesus Christ of Latter-day Saints is to prepare the sons and daughters of God for their destiny—to become like our heavenly parents.
>
> Our eternal destiny—exaltation in the celestial kingdom—is made possible only through the atonement of Jesus Christ (through which we became and can remain "innocent before God" (D&C 93:38[3]) and is only available to a man and a woman who have entered into and been faithful to the covenants of an eternal marriage in a temple of God (D&C 131:1–4, D&C 132). . . .
>
> Because Satan desires that "all men might be miserable like unto himself" (2 Nephi 2:27[4], Abraham 3:25–26), his most strenuous efforts are directed at encouraging those choices and actions that will thwart God's plan for his children. He seeks to undermine the principle of individual accountability, to persuade us to misuse our sacred powers of procreation, to discourage marriage and childbearing by worthy men and women, and to confuse what it means to be male or female. (Oaks, 1995)

Latter-day Saints Are Taught That There Is a Gendered Deity—A Father and a Mother in Heaven

Unique among Christian denominations, The Church of Jesus Christ of Latter-day Saints teaches that God the Eternal Father is an immortal, glorified, exalted physical Being, and that God the Father and His resurrected Son, Jesus Christ, and the Holy Ghost are three separate and distinct Beings, who are one in mind and purpose. "The Father has a body of flesh and bones as tangible as man's; the Son also; but the Holy Ghost has not a body of flesh and bones but is a personage of Spirit" (D&C 130:22; see also Luke 24:36–39).

The Church of Jesus Christ of Latter-day Saints teaches members (including very young children) that they have both a Father and a Mother in Heaven, in whose image they have been created, "as a human being—male or female—a spirit son or daughter of heavenly parents." These members of the Church will likely believe that in a premortal existence they "knew and worshipped God as their Eternal Father and accepted His plan by which His children could obtain a physical body and gain earthly experience to progress toward perfection and ultimately realize their divine destiny as heirs of eternal life" (The Family: A Proclamation to the World, 1995[5]).

[3] "D&C" is a citation to the *Doctrine and Covenants of The Church of Jesus Christ of Latter-day Saints*, a volume containing revelations given to Joseph Smith, the first prophet and President of the Church, and some additions by his successors. Latter-day Saints accept the Doctrine and Covenants as scripture alongside the Holy Bible and the Book of Mormon. The citation is to section number and verse.

[4] This is a citation to the Book of Mormon: Another Testament of Jesus Christ.

[5] From time to time, the General Authorities of The Church of Jesus Christ of Latter-day Saints issue statements of doctrinal clarification or direction regarding important gospel principles.

While there is considerable clarity regarding the role of our Father in Heaven (similar in many aspects to general Christian thought), there is limited specificity regarding the exact role and responsibilities of a Heavenly Mother, though the concept is a long held and cherished belief among Latter-day Saints (Paulsen & Pulido, 1920). Susa Young Gates, the daughter of Church President Brigham Young, and a prominent writer, periodical editor, women's right advocate, and leader in the Church, wrote in 1920 that Joseph Smith (the founder of The Church of Jesus Christ of Latter-day Saints) asserted the truth that "the divine Mother, [is] side by side with the divine Father" (Gates, 1920). Even earlier, in 1910, Elder Rudger Clawson, Church leader and editor of the Latter-day Saints *Millennial Star* publication wrote, "We honor woman when we acknowledge Godhood in her eternal Prototype" (Clawson, 1910).

Why is this understanding so important for therapists working with a Latter-day Saint client? For members of The Church of Jesus Christ of Latter-day Saints, this rather unique understanding of the nature of God, their relationship to Deity, the importance of gender, and their existence as literal spirit children of heavenly parents gives particular meaning to the significance of being male or female. Much of a Latter-day Saint's personal identity and understanding of their place in the world and in a future eternity may be tied to their believed place in this pre- to post-mortal family constellation. Their concept of gender identity and role and purpose of human sexuality may not really be very flexible for them. The therapist needs to be aware that asking a Latter-day Saint client to challenge some of his or her personal assumptions on sexuality and gender can elicit profound emotional vulnerability.

Latter-day Saints Are Taught They Existed as Gendered, Premortal Spirits—Male and Female

Among the many religions of the world, there is a wide diversity of opinion regarding when and how the soul or spirit of an individual enters the physical body. However, most Christian denominations accept the doctrine of "creationism." For example, the traditional philosophy of the Roman Catholic Church holds that the rational soul is created by God at the moment it is infused into the new organism.[6] "Traducianism," on the other hand, is the belief that an individual's soul is derived from the souls of the individual's parents and enters the organism at the time of birth. Still other religions, or philosophical schools, assert their belief in "ex nihilo" creation, believing the soul of man was "created out of nothing" or was created from "eternal matter." However Latter-day Saint doctrine specifically rejects creationism, traducianism, and ex nihilo creation. In contrast, Latter-day Saints believe in the "premortal existence" of the souls of man.

Members of The Church of Jesus Christ of Latter-day Saints are taught their gendered spirits existed long before they came to earth to occupy mortal bodies (in fact, long before the earth was created). According to this unique Latter-day Saint doctrine, every individual first existed as an intelligence. Then, as Church leader Melvin J. Ballard taught, "In due time that intelligence was given a spirit body, becoming the spirit child of God the Eternal Father and his beloved companion, the Mother in Heaven. This spirit, inhabited by the singular, eternal intelligence, took the form of its creators and is in their image" (Ballard, 1949).

[6] *Dogma*, Dis seminary, August 2005, According to the ruling opinion of Catholic Theologians the human soul is not received by parental propagation (traducianism), but by immediate divine creation (creationism).

In 1995, the First Presidency of the Church released "The Family: A Proclamation to the World," which elaborated on this doctrine of a pre-mortal spirit existence and added an additional clarification on the nature of gender: "All human beings—male and female—are created in the image of God. Each is a beloved spirit son or daughter of heavenly parents, and, as such, each has a divine nature and destiny. Gender is an essential characteristic of individual premortal, mortal, and eternal identity and purpose" (The Family Proclamation, 1995).

Thus, Latter-day Saints teach that we all had binary gendered spirits before coming to earth, and that this is part of our eternal identity. A man's or a woman's spirit was not created by the child's parents upon conception, or at the moment of physical birth into this world and, thus, is not subject to the potential flaws of the mortal body's physical delivery system.

Latter-day Saints Are Taught That Sexuality Is Intended for Married, Male and Female Individuals Who Hope to Create Eternal Families

Most therapists are aware that The Church of Jesus Christ of Latter-day Saints continues to oppose, and declines to recognize, same-sex unions as "marriages," in the true (and eternal) sense of the word. While an elaboration on that specific policy is not warranted in this article, an understanding of the unique Later-day perspective on the nature of sexuality, procreation, marriage, and families is important.

In simple terms, Latter-day Saints believe that we came to earth to receive a mortal body to house our spirits. These bodies have many purposes, but the most important objective is to participate in a family, make sacred promises to God, and create (when possible) a family of their own. The procreative process is sacred and reserved for marriage. Ideally, a man and woman have children and then those children are sealed to them—generation after generation—becoming an extended, eternal family. It would be difficult to overstate how thoroughly this idea is embedded into every aspect of Church teaching and informs and provides the foundation for the Latter-day Saint world-view.

For members of The Church of Jesus Christ of Latter-day Saints, marriages and families don't necessarily end at death[7] (Gardner, 1980).

> We can picture ourselves home again with our Heavenly Parents in that wonderful place, not only as sons and daughters, but husbands and wives, fathers and mothers, grandfathers and grandmothers, grandsons and granddaughters, bound together forever in loving families. (Eyring, 1998)

Your client has been taught that family relationships, which are sealed under divinely delegated authority in a Church temple, and in which the members are faithful to the covenants made there, will extend beyond the grave.

Thus, in the therapeutic process, avoid encouraging a member of the Church of Jesus Christ to move into an emotionally closer, intimate, sexual relationship, or to try cohabitation with, or to enter into a formal marriage with a same-sex partner. This only exacerbates the client's situation and deepens the client's sense of guilt, especially until they have tried other means to satisfy their desires for validation. Weekly same-sex therapy groups can help your client meet this

[7] Latter-day Saint children sing about how families can be together forever.

need, as well as the client's attendance, with other same-sex friends, at public athletic events. Also helpful in deepening same-sex friendships are client's participation in such physical activities as biking with friends, golf, mountain climbing, or working with community volunteer projects, such as Habitat for Humanity, local food kitchens, medical outreach events, political gatherings, or other charitable activities.

This type of service to others, is a large part of the LDS culture and provides great opportunity for clients, who have been reared in the Church, to feel comfortable in reaching out to others in need and even in gathering a group of friends to tackle most any kind of project. This process, of serving, assisting, and learning from others in need, also provides a healthy diversion from too much self-concern or falling victim to detrimental, unhelpful feelings of personal loss and grief. Such service projects are all around us and can be easily vetted by checking with local public, religious, or private organizations.

The Church of Jesus Christ of Latter-day Saints sponsors recreational group activities for individuals of any age (i.e. children's play groups, teenage bike and hiking trips, young adult soccer or spelunking or dance activities, middle-age home repair or fishing or sailing trips, and old-age gardening and quilting), and all projects are open to members of any other social or religious groups.

Your LDS client will certainly understand that, according to Church doctrine and teachings, sex has no truly meaningful purpose or place in their life unless they are legally married to an individual of the opposite sex. Of course, Latter-day Saints and their Church authorities understand that sex does, and should occur, between married men and women even without the possibility of procreation. Latter-day Saint doctrine takes a very healthy and positive view of sexual intimacy within marriage. Further, Church leaders, place a high priority on protecting a mother's health and other possible physical and emotional needs of married couples, as those couples consider whether to take steps to prevent conception.

Latter-day Saints Believe Sexual Thoughts and Behaviors and Human Hearts Can Be Changed, through Their Efforts and with the Help of the Lord

Members of the Church believe "all mankind [including themselves] may be saved" by obedience to the laws and ordinances of the Gospel" (Smith, 1842)[8]. However, those who struggle with unwanted same-sex attractions or gender dysphoria may be worried they have lost their opportunity to "ultimately realize their divine destiny, as heirs of eternal life," through "the divine plan of happiness (which) enables family relationships to be perpetrated beyond the grave," (Mouritsen, 1947; The Family Proclamation, 1995) all because of their inability to be sexually attracted to members of the opposite sex.

Because Latter-day Saint clients may be afraid, or may have become convinced, there is no hope of their ever being able to have a marriage and family, it is important they process this particular concept in light of their understanding of the basic principles of their Church. Your Latter-day Saint client has been taught from childhood (or since joining the Church) to believe that because of the unfathomable love of our Savior and heavenly parents, any individual who aspires to achieve whatever status they hope for in eternity, and who is willing to follow the path to get there, will be granted that status, despite whatever physical, emotional, or

[8] This is a quotation from Article 3, of thirteen basic beliefs held by the Church of Jesus Christ, now known as the "Articles of Faith," which were written by Joseph Smith, in response to the request from John Wentworth of the *Chicago Democrat*.

spiritual challenges they face, no matter how long it takes, or how many times they may slip off the path during the process.

We, also, have learned as professional therapists, and need to reflect to our clients, the truth that unwanted same-sex attraction and behaviors are not "innate and immutable." Research has demonstrated that whatever biological factors or conditions might present in a client's thoughts, desires, or compulsions, they are "predisposing" not "predetermining" (Byrd, 2009).

As a result, it is important that, as part of our process of forming a strong therapeutic alliance with a Latter-day Saint client, he (or she) should be encouraged to share with the therapist his (or her) understanding of his personal relationship with Deity and long-range hopes for an "eternal marriage and family." Often it is helpful to ask a client to visualize himself or herself in the future, imagine "what" and "where" the client would like to be in two years or even ten years from the present time (whatever the client's hopes may be) and agree to commit those scenarios to writing. Then ask your client to share them with you, as they are ready to do so. The positive visions and hopes clients list, as drawn from their thoughts and inculcated belief system, can then be used by the therapist (whatever the therapist's preferred treatment modality), to strengthen the client's ability to move forward in the therapeutic process.

Latter-day Saint clients need to be supported in their belief that "with God all things are possible" (Matt. 19:26) and "there is time, both in this life and in the life to come, during which changes in heart, behaviors, and even in interpersonal attractions, can be realized" (Holland, 2017).[9] The Lord understands our trials, especially those faced by human beings struggling with unwanted sexual attractions and beliefs, and if we keep trying and truly repent, each time we slip off the path and do something contrary to divine commandment, He will forgive us, even daily, until we reach our goal (Robbins, 2018)[10]. This process of continual effort and progressive change, over time, is essential to achieving our eternal potential under God's plan of salvation for His spirit children (Plan of Salvation, 1830). Further, it is critical that the client be encouraged to remember every opportunity and blessing under the plan of salvation is available to any and every individual, including the client personally (John 14:13) and not just to other people who may not face the same particular personal and family challenges as the client.

If for any reason, your client is completely unable to relate to the possible promise of "peace in this world, and eternal life in the world to come" that is the consequence of faithful living (D&C 59:23), or seems to be exhibiting any other signs of increasing and persistent depression, the client must be carefully monitored for possible self-harm activity and suicidal ideation. Assist him or her to discuss, reconsider and revise their immediate objectives, by lowering their level of expectations and possibly extending the length of time required to reach their selected goals. Help your client to step back from their original plan of action and craft a more conservative plan for the immediate future, with more concrete achievable steps to reach their goals. Further, if your LDS client is particularly emotionally vulnerable, such a

[9] Elder Jeffrey R. Holland stated, "If we persevere, then somewhere in eternity our refinement will be finished and complete—which is the New Testament meaning of *perfection*."

[10] "To become like Him will require countless second chances in our day-to-day struggles with the natural man." (Lynn G. Robbins)

plan might also include a suicide prevention contract signed by you both.

When you feel it may be appropriate, ask your client to share with you what the Church teaches about their life before they came to earth. You may get any number of responses from your client, but if the quality of your therapeutic relationship allows them to be fairly transparent, he or she will express their belief that they lived as a spirit with heavenly parents. The client may elaborate that he or she was one of the spirits, who decided to come to earth, each to gain a physical body and, thus, to experience very challenging problems just as those you are discussing in the course of therapy. Your client will understand that, though he or she lived a very long time in that premortal life, and assuredly discussed what life might be like on earth, with no real experience, there is no way they could have fully understood how difficult this life would actually be.

Given this much-expanded vision of his or her life process, and with an understanding of how far they have already come in the past, your LDS client will likely also express the belief that he or she is never really alone. Encourage your client to tell you about any feelings and ideas regarding which of their family members or friends (who have passed on) may be aware of their struggles and may, at times, be nearby to help them manage their trials and to allay their fears.

Many of the members of The Church of Jesus Christ of Latter-day Saints have what is called a written and recorded patriarchal blessing, as given to them by a priesthood leader, to help them learn about who they are, their strengths, individual gifts, and the challenges they may face in this life. Though the client will not (and should not) share that document with you, because they hold it to be sacred, your client may share some of the positive encouragement and eternal promises it contains. You can ask your client what their blessing means to them and encourage him or her to remember that the blessing is another bit of evidence of how much the Lord loves and attempts to support them during these difficult times.

During the balance of your work with your Latter-day Saint client, you will need to assist him or her, to continue to review his or her options, to work on self-management skills, to repent, and to forgive themselves, as often as needed, even "until seventy times seven" (Matt. 18:22) as he or she moves forward along the path to their goals. Whenever possible, review with your client how difficult this journey is for anyone, and that it takes time and a great deal of patience. Point out how the successes he or she has experienced along the way have been substantial and better than they had expected. Further, take time to help your client step back and review the progress he or she has made on their large view, the overall plan to acquire peace in this life, or review his or her progress toward an intermediate goal along that path, or whatever other accomplishment will leave them feeling their current struggles are not in vain and, most importantly, with hope for further progress in the future.

In summary, it is common practice for therapists, during their standard process of clinical counseling, to encourage clients to step out of their comfort zone and try something that may seem a little unsettling. For example, throughout that therapeutic process, we often will encourage a client who may see himself (or herself) as "shy" to make an effort to talk to someone they would like to meet or get to know better. For a client who desires to appear less "conventional" in their physical presentation, we might support his or her idea of trying a new hairstyle or a different wardrobe. Some therapists working with a client who expresses a desire to become more socially integrated with peers may support that client's expressed desire to move in with another individual, to see if that will, as they hope, improve his or her ability

to establish closer social and emotional connections with others. However, understanding the difference between encouraging such new experiences and destabilizing what may be essential building blocks in your Latter-day Saint client's unique personal identity and security, such as we have discussed, will rest upon your knowledge and caring appreciation of the religious, social, and cultural context of that LDS client's life.

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Serving Clients with Unwanted Same-Sex Attraction and Behavior as Catholics: A Qualitative Study

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Fourteen Catholic mental and medical healthcare professionals known by the author through his involvement with them in activities sponsored by one or more professional organizations and/or Catholic ministry responded to a questionnaire asking how their Catholic faith influences their service to persons with unwanted same-sex attraction and behavior. This paper summarizes the respondents' comments regarding how they find that the Catholic worldview is a positive resource for their practice, what therapeutic theoretical orientations guide and techniques are used in their practice, what spiritual/religious and other resources and activities they recommend that their clients or patients practice along with receiving their professional care, and how they respond differently to persons of non-Catholic Christian, other, and no religious faith. The respondents' comments are discussed in light of the professional ethical principles to "do no harm," "do good," and respect clients' right to practice religious faith as they determine.

Keywords: same-sex attraction, psychotherapy, ethics, Catholicism, psychological/spiritual integration

This study was inspired by my writing of the paper "Serving Persons with (Unwanted) Same-Sex Attraction and Behavior (SSA) from the Roman Catholic Tradition" (Sutton, 2019) for the *Journal of Human Sexuality*. I originally envisioned it as a way of operationalizing one of the teachings of the Roman Catholic Church on the proper relationship between her teaching and that of contemporary, secular "arts and sciences." Briefly, those responsible for educating and preserving the Church's *Magisterium* ("teaching authority") on matters of "faith and morals" defer to the knowledge, wisdom, and experience of professions in the medical and mental arts and sciences, as long as the latter recognizes and respects the former (cf. Sutton, 2019).

A lengthy quote from this paper seems appropriate here:

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> In *Christifideles Laici* (1988), [Pope John Paul II] similarly challenges *all* Catholics who serve as scientists, scholars and mental and mental healthcare professionals to become . . . faithful to their education and training as authentic, genuine professionals in their respective disciplines. He exhorts the "lay faithful" to "accomplish their work with professional competence, with human honesty, and with a Christian spirit, and especially as a way of their own sanctification" (no. 43). . . . [W]orking this way is a "pastoral urgency" since a human culture has developed which now has become "disassociated not only from Christian faith but even from human values." In such a culture, "science and technology (themselves) are powerless in giving an adequate response to the pressing questions of truth and well-being that burn in people's hearts." (no. 44)
>
> Pope John Paul II [also] affirms the need for "teachers and professors" to recognize and preserve "the autonomy of various sciences and disciplines" while performing their "Christian inspired" work as "faithful (and) true witnesses of the gospel, through their example of life, their professional competence and uprightness." He asserts: "It is of singular importance that scientific and technological research done by the faithful be correct from the standpoint of service to an individual in the totality of the context of (his or her) values and needs" (no. 62). (Sutton, 2019, p. 31)

So, when composing the paper, I asked Catholic colleagues questions which would offer wisdom about how some Catholic mental and medical healthcare professionals integrate their professional education, training, experience, and competence with their efforts to be[come] "faithful [and] true witnesses of the gospel." Demands of time and space prevented my integrating my colleagues' responses into the body of the—already more than long enough—paper, so I resolved to write a separate paper summarizing their views. This paper is the fruit of those efforts.

Method and Research Participants

Method and Sample Selection

A questionnaire (see Appendix) was emailed to fifteen colleagues whom I knew from personal conversations and at times their public writing and speaking to be "practicing and devout" Roman Catholics,[2] through my involvement with a number of professional and ministry organizations. Their affiliations included the Alliance for Therapeutic Choice and Scientific Integrity (https://www.therapeuticchoice.com), the American College of Pediatricians (https://acpeds.org/), the Catholic Medical Association (www.cathmed.org), the Catholic Psychotherapy Association (www.catholicpsychotherapy.org), and the Courage and EnCourage Apostolate (couragerc.org). Three of the seventeen did not submit completed questionnaires. One reported that he was not serving clients with SSA at this time; a second that he lacked the time at present; and a third, not known to me and recommended "secondhand," did not respond to the initial request, or a follow-up

[2] To me, "practicing and devout" Roman Catholics are persons who have been baptized, received the other sacraments of "Christian initiation," and try to faithfully and sincerely live their Christian lives under the guidance of the Church's *magisterium* or authentic teaching authority—and relevant authorities.

reminder email two weeks later, which was sent to all intended respondents.

Sample Personal and Professional Demographics

Five of the respondents were women and nine were men. Their ages ranged from 43 to 70, with a median age of 56.5 years. Ten were born, raised, and continue living as Roman Catholics, while four were "adult converts," who reported practicing Catholic Christianity as adults for the past 23–40 years. Four were licensed physicians, who specialized in internal medicine, pediatrics, and psychiatry (two). Four were licensed psychologists, four mental health counselors, three marriage and family therapists, and one as a chemical dependency counselor, with three respondents reporting multiple licenses. Professionally, respondents reported having served clients with SSA from 7–40 years (median of 17) and in their active caseload serve an average of from less than one to 20 (median of 4) clients.[3]

Therapeutic Orientations and Interventions Guiding Respondents' Professional Practice

Respondents gave essentially the same, when not identical, answers to the questions: "What particular therapeutic orientations and interventions guide your professional practice serving all clients?" And, "clients with unwanted SSA in particular?" So, a summary of respondents' answers to the question of what therapeutic orientations and interventions guide their professional service to clients with unwanted SSA follows. In general, professionals reported a number of theories and/or therapeutic techniques which guide how they try to understand and/or actually serve persons with SSA.

Therapeutic Approaches

The ones mentioned are listed in alphabetical order using the names listed by the respondents. If more than one respondent mentioned the same approach, the number of respondents who did so is in parentheses following the name. When a more specific approach or technique is listed, links for more information follow the name.

- Adaptive Information Processing
- Affect focused/Gestalt (2): Baars-Terruwe Model (https://baarsinstitute.com/)
- Bibliotherapy (see below for recommended texts)
- "Body work" (AEDP, https://aedpinstitute.org/)
- Cognitive-Behavioral Therapy (5)
- Client-Centered
- Emotionally Focused Therapy (https://iceeft.com/)
- EMDR (https://www.emdr.com) (5)
- Humanistic/Existential (2)
- Family Systems/Couple Therapy (2)
- Image Transformation Therapy (http://www.imttherapy.com/) (4)
- Inner Child Work (including Transactional Analysis) (2)
- Interpersonal (Byrd, n.d.); Mindfulness / Relaxation Training (2)
- Object Relations/Psychoanalytic (3)
- Psychoeducational
- Reintegrative Therapy (https://www.reintegrativetherapy.com/reintegrative-therapy) (2)
- Nicolosi Reparative/Attachment Therapy (4)

[3] For convenience sake, unless directly quoting a physician the word "client(s)" will be used when referring generally to persons who are receiving professional care of any kind.

- SAFE-T Guidelines (Alliance, 2018)
- Solution-Focused Brief Therapy (http://www.sfbta.org/)
- Trauma & Attachment Therapy (3)
- Twelve-Step Work

Theoretical Approaches

In addition to reporting themselves practicing in an "eclectic" manner, a few explicitly described their guiding theoretical orientations as eclectic as well. One wrote succinctly: "*I believe in a holistic view of the patient, body, mind and spirit.*" A second:

> *I consider myself Behavioral or Cognitive Behavior, however, I could use Humanistic/ Existential and Psychoanalytic ideas in my work. Attachment theory and Adaptive Information Processing theory (from the EMDR literature) also guides my work.*

A third reported:

> *I tend to be more psychodynamically oriented, but lately I have been using cognitive-behavioral interventions for embedded cognitive distortions. I also use Object Relations Theory to help clients explore their need for secure attachment. My most recent professional interest has been in a new therapy for trauma called Image Transformation Therapy: http://www.imttherapy.com/.*

And a final professional responded in detail, listing areas of intervention more than theoretical orientations or intervention techniques.

> *My training included particular attention to the role of family throughout the lifespan and of course other significant relationships in the person's past and immediate experience; Attachment theory holds great value for my practice and understanding of the development of the human person; I do take an honest and direct approach to therapy—goal setting, role play, and attention to behaviors are key themes. . . . Attention to narcissistic tendencies; mother and father wounds; experiences of boundary violations and abuse; exploration of the human person—the person's sense of being male/female and what experiences guided this understanding. I refer out for addiction and significant trauma issues.*

As used above, "eclectic" is a fair description of the overall way which these Catholic professionals report conceptualizing cases and serving their clients who report SSA. This is not surprising in two ways. First, as mentioned above, the youngest respondent was 43 years old and the median 56.5 years old. Citing multiple sources, Lambert (2013a, 2013b) reports that it is the norm, not the exception that the longer psychotherapists practice, the more eclectic they become. No matter how "cutting edge" the therapeutic approach is in which they are trained, therapists over time learn and use concepts and techniques from other approaches.

In another way, the fact that these mental and medical healthcare professionals report serving clients and patients with unwanted SSA in many different ways illustrates the history of such care. Over a century of clinical and research reports (Phelan, 2014; Phelan, Whitehead & Sutton, 2008) document that physicians and therapists have served clients who wanted professional help to better manage and resolve same-sex

attractions and behaviors with some effectiveness.[4]

Respondents' Views on How Their Catholic Faith Influences Their Professional Service to Clients with Unwanted SSA

There was some overlap in the questions being asked, as well as redundancy in the answers given by respondents. What follows is an integrated summary of the respondents' answers to the questions asked in the research questionnaire (see Appendix). When appropriate, as above, particular responses are quoted verbatim. In most cases, respondents are not identified by sex and in only case by profession.

In general, respondents reported a comfortable integration of their being and living as Catholic Christians on the one hand and serving as medical and mental healthcare professionals on the other. They expressed this in a number of ways, particularly with gratitude for how their understanding of our faith allows them to better conceptualize what their clients are dealing with, what they can do in therapy to be the most helpful, and what they can suggest for clients outside of therapy for their ongoing healing, growth, and maturing in their chosen life paths.

The Importance of the Catholic Worldview

Respondents often repeated their Catholic faith gives them the "Christian anthropology" or "philosophical understanding of human nature and the human person," which enables them to have an essential perspective which guides their professional service to particular clients as persons. One respondent reported:

> *In using a Catholic understanding of human anthropology I see this issue as one of natural law.*[5] *God's design of human sexuality is one of complementarity between the sexes.*

Another wrote:

> *My traditional conservative Catholic faith allows me to understand God's plan for humanity, the definition of "normal" and what constitutes a disorder. This forms the foundation for my work.*

A third respondent stated that Catholic teaching provided

> *a coherent understanding of the human person as made in the image after the likeness of God as male or female and oriented sexually to the other*. [If clients] *are able to accept* [such a] *a normative base, . . . then the goals of intervention are clear, and there can be hope and perhaps even increased confidence in healing or at least some relief.*

And a fourth commented:

> *Having a Catholic anthropology, including its implications for sexuality, the complementarity of male and female, and marriage gives me a firm foundation with which to address the whys and why-nots that people who have unwanted SSA sometimes bring to counseling*.

[4] These reports also document that while some clients experience their SSA much diminished and/or opposite-sex attraction and behavior much increased, others experience less change and still others little or none (Alliance, 2012).

[5] See Sutton (2019) for an explanation of the "Natural Law."

One respondent summarized these ideas about "anthropology, foundation, framework, normative base and Natural Law" as follows:

> *My Catholic faith informs me that God's plan is for the happiness of each human person. Reason informed by Faith helps me to see how God has created human nature, and therefore what the goals are for therapy in general become clear. I would say my faith also helps me to be attentive to and affirming towards the suffering of these clients, no matter how they see themselves or what they have done. . . . It is nice to be able to speak about the love and mercy of God for my clients, too.*

For, the faith also can provide *"a sense of identity to clients with a weak sense of Self*."

Resources Recommended for Clients to Do Outside of Sessions

Religious/Spiritual

For Catholic clients, most respondents specifically recommended encouraging Catholic clients to use prayer, including Eucharistic adoration and other forms of meditation/contemplation; Bible reading; devotion to the saints; and participation in and experiencing the grace of the sacraments, notably the *Eucharist* and *Reconciliation*. One respondent also mentioned the *Anointing of the Sick*, were a client suffering from particular medical difficulties.

Devotion to Mary, the Mother of Jesus, and other saints was particularly mentioned by several respondents, who also emphasized that they'd likely encourage only Catholic clients to do. One respondent wrote:

> *Catholics can not only receive fathering from our Father in Heaven, but they can receive mothering from Mary. Given the attachment problems of many, having a mother in Mary is a special support and help*.

One respondent shared that his faith "*enables me to know the efficacy of the Sacraments and prayer, which I recommend to them as I can*." Another summarized:

> *Three Catholic practices can be particularly helpful for clients with unwanted SSA: 1) The power of Eucharistic adoration for direct-though-mysterious healing for SSA; 2) The help of the communion of saints for the client to encounter always-available, totally-attuned, utterly-healthy male and female father, brother, mother, and sister figures; 3) The healing power of lectio divina, when Scripture passages addressing parental wounds, shame, and self-hatred are prayed through.*

Respondents voiced that they encourage their Catholic clients—and non-Catholic Christian ones when appropriate—to experience the spiritual and psychological benefits which regular and devout spiritual and religious practices can provide, which the professionals themselves do and have experienced in their personal and sometimes professional lives. One stated: "*I have had spiritual experiences that have strengthened me for my work, types of experiences I uniquely learned about from Catholic spirituality*." Several respondents mentioned the need and value of being guided by the Holy Spirit *during* sessions. One noted: "*Whenever I do therapy, I try to maintain a constant attunement to the Holy Spirit's leading regarding what to say or not to say*." Another wrote: "*I also bring Christ into the session by letting the Holy Spirit guide my*

words, actions and clinical decisions, if not necessarily overtly so."

A third commented: "*I treat all patients the same. But I also am not afraid to pray with patients when appropriate*." Regarding praying, "*directly praying*" for and/or with clients in session, one respondent reported, "*I always ask permission for that*" as "*not all clients are comfortable with my*" doing so. And a fourth wrote: "*Borrowing from what works with my Protestant clients, I can formulate a confrontation from Scripture where needed, especially to address distorted spirituality being justified by misinterpretation of Scripture."* He then clarified: *"I have actually done that more for Protestants who know the Bible*."

Supportive Activities

Along with private and public spiritual and religious practices for faith-based clients, respondents recommend a number of other activities, which they believe support their mental health and medical services. Several respondents reported recommending that clients participate in relevant Twelve Step Programs and the Courage Apostolate, if Catholic. One respondent advises male clients to "get a mentor, coach, or personal trainer so that they can experience first-hand what it's like to have another male interested and invested in them and in their well-being."

Several professionals wrote that they encourage "journaling," one emphasizing "emotional journaling." Another described asking clients to write a "*timeline for their life*" using the "*SPICE acronym: Spiritual, Physical, Intellectual, Communicative, Emotional*" as a guide for exploring one's past, present, and future life and setting goals. Respondents also encourage that clients "*exercise*," and practice "*relaxation*" and what one called *"soulfulness (which is my version of 'mindfulness')."* And whatever a client's goals for therapy, if they report practicing no religious faith, one professional wrote: "*I just leave faith out of the equation. All other techniques are the same. I do often mention "higher power" again and most clients can apply this as they see fit. This works with mindfulness meditation which can be generic in nature."*

Referring for Pastoral Care

When asked whether and when respondents refer clients for pastoral care, their responses were generally the same. Respondents encourage them to do so, especially if they already have *"a regular confessor or spiritual director,"* or seem to have questions about or issue with the faith which the professionals do not think they are able to address. As one respondent advised: "*Almost all circumstances would warrant this, if the person is not alienated from the Church*." Another professional emphasized the importance of consulting and collaborating "*with a trusted and particularly educated priest on complex theological questions of sexual or other practice or behavior*."

About half of the respondents mentioned that at times referring for pastoral care may be a difficult decision to make. These professionals expressed concerns about whether a particular pastor, confessor, or spiritual director might understand or talk to a client with SSA from the "mind and heart of the Church." One respondent stated he would refer *"when the patient is ready and a priest with a good understanding of the dynamic of SSA is available."* Another wrote: "*Most of the time I encourage this, as long as the spiritual director is healthy and knowledgeable about their condition and will not interfere with treatment."* A third noted that he would refer for pastoral care *"when the priest is able not to diminish and not to overstate the problem."* Another responded: "*I would collaborate with Catholic clergy if I could be sure that they would not soften Church teaching on homosexuality."*

And, one respondent addressed a timely concern for a small minority of Catholics who now experience SSA following clerical sexual abuse. This respondent wrote:

> *[For a Roman Catholic] client, a referral for pastoral care would almost always be an important component, unless they have had prior negative experiences (abuse, dismissiveness) which would perhaps then warrant a delay in doing so.*

Particular Concerns Serving Persons of Faith

When asked about particular concerns which they experience serving persons of faith, many respondents mentioned two: *forgiveness* and *scrupulosity*.

Forgiveness

Seeking God's forgiveness for one's offenses and forgiving others as we would want to be forgiven ourselves are key aspects of Christian living. Respondents mentioned that the issue of "*forgiveness*" can be a challenge for their Christian clients with SSA. In terms of seeking forgiveness, several mentioned encouraging Catholic clients to participate in "Confession," the sacrament of Reconciliation.

More respondents commented on the challenges of forgiving others for having offended them. One respondent explained that there is a proper timing for encouraging the practice of forgiveness. Especially for those "*at an addictive level of functioning*," it is important for them to first achieve "*some measure of continence*" or self-control of their behavior(s). Then, it may be helpful to "*switch to grief and forgiveness, particularly within a family context*."

Several respondents reported that some clients may want or try to forgive before they're ready. One professional wrote: "*I am cautious about introducing the topic of forgiveness because "premature" forgiveness is a problem with Catholics and sometimes discussing forgiveness too early is invalidating to their trauma."* A second explained further:

> *Some Catholics are too quick to forgive or forgive without the associated emotional processing of their traumas in a way that is unhealthy. Psycho-education must help them to understand how to forgive in a way that will be most healing and the least harmful to their selves.*

Overall, respondents seemed to recognize that the asking for and giving of forgiveness is a challenging process with significant benefits when done in a timely, effective way (cf. Enright, 2015; Enright & Fitzgibbons, 2014).

Scrupulosity

When asked in what way(s) clients' particular practice of faith may most hinder their participation in and cooperation with professional care, a number of respondents mentioned the difficulty of "*scrupulosity.*" One defined this as *"religious obsessive compulsiveness."* Another stated that if clients "*have scrupulosity to the degree of having an intractable diagnosis of OCD, then the treatment can be difficult*." A third responded:

> *The word scrupulosity comes to mind related to your question; and the observation that some people view faith as something sort of "magical" in nature; if I do this (pray a certain way or for) a certain number of times, etc. then this will happen. It's important to offer an understanding of the human person with many*

> *dimensions, faith being one of them, and then begin to consider what areas of their life they want to focus on in treatment.*

One professional explained: "*If (clients) labor under scrupulosity or false guilt, they may have a difficult time opening up more deeply for fear of being condemned*." Another reported that paradoxically (over-) using the sacrament of Confession may be self-defeating for someone dealing with a true "*scrupulous compulsion*" based on "*a repressive neurosis*" (cf. Baars, 2003; Baars & Terruwe, 2003; Terruwe & Baars 2016). Clients with SSA who also experience an obsessive-compulsive disorder (OCD) concerning religious or moral matters (i.e., "scrupulosity") may need to work first on their OCD. As one respondent wrote:

> *The only time I see faith get in the way of treatment is if they are prone to a rigid or fundamentalist-type of faith understanding. Also I had one man who was prone to scrupulosity. This strongly suggested OCD symptoms. With this present, I had to slow the process down. I had to address the scrupulosity first before I could even begin to tackle the SSA. Once this was successfully addressed, then it was much easier to deal with the underlying SSA causes. Although in dealing with the OCD, it often helped resolve some of the SSA root causes, as they often stemmed from the same sources.*

Bibliotherapy and Other Recommended Aides[6]

Bibliotherapy

A number of respondents reported using "bibliography" to support their clients' efforts to deal with unwanted SSA. In addition to reading and meditating on the Bible, one professional reported encouraging clients "to read the *Catechism* (*of the Catholic Church*, 1994) if they have any questions about the Catholic faith." Many respondents listed a number of specific books and similar resources which they recommend to clients.

Some of the books recommended focus on managing and overcoming SSA, some from a more professional, others a more pastoral perspective. Recommended resources include, in alphabetical order by author:

> Catholic Medical Association's (1999) *Homosexuality and Hope; Courage/EnCourage* resources (https://couragerc.org/); *Floyd Godfrey's* (2012) *A Young Man's Journey;* Fr. John Harvey, OSFS's (1996) *The Truth about Homosexuality*; Medinger's (2000) *Growth into Manhood: Resuming the Journey*; and Joseph Nicolosi's (n.d.) *SBSS—Shame Based Self Statement, Healing Homosexuality* (1993)*, Shame and Attachment Loss* (2009), and *Reparative Therapy of Male Homosexuality* (2020).

Another set of recommended readings focus on achieving sexual and/or psychological healing and maturity in general, with a more professional but sometimes pastoral emphasis. These include:

> Dan Allender's (2008) *The Wounded Heart* ("For those with whom sexual abuse has been a factor"); Baars's *(2003) Feeling and Healing Your Emotions;* Baars & Terruwe's *(2003) Healing the Unaffirmed; Psychic*

[6] Books and other resources recommended by respondents are listed in **References Recommended by Respondents,** which occurs after the normal **References** list.

Wholeness & Healing by Fr. Benedict Groeschel; CFR's *Courage to Be Chaste;* and Seamands's *(2015) Healing for Damaged Emotions.*

A third set of books deal more with helping clients—and professionals—grow in understanding themselves and others from an existential, spiritual perspective. "Because the question of suffering can be so prominent," one respondent "may recommend": Corrie ten Boom's *The Hiding Place* (2006), or Viktor Frankl's *Man's Search for Meaning* (1993). For Catholic Christians who may benefit from what one respondent calls "soulfulness"—i.e., experiencing through Judeo-Christian meditation and contemplation the genuine benefits of current mental health advocacy of "mindfulness"—another respondent advises reading *The Mindful Catholic: Finding God One Moment at a Time* by Bottaro (2018). And to help all professionals, and interested clients, learn a genuine "Christian Anthropology," *The Catholic Christian Meta Model of the Person* (Vitz, Titus & Nordling, 2020) is recommended by one professional.

One professional reported using what a client is already reading or hearing from speakers to guide discussions in therapy. "*I ask if they have heard of any particular speakers, books etc. and then we talk about those if I'm familiar with them; if not, I ask them to tell me more, i.e. what is the message, what seems helpful/unhelpful."*

Other Recommended Therapeutic Resources

In addition to bibliotherapy and religious and spiritual aides, respondents mentioned a number of other resources which they recommended that clients participate in or otherwise use. Several mentioned that they encourage involvement in "Twelve Step Programs," others "Courage meetings," and still another "Journey into Manhood" weekends. A couple of respondents refer men to participate in "men's groups in the parish or diocese," for developing male support and friendship. And another recommends that clients listen to audiotapes which stimulate self-relaxation and "psychic incarnation" through experiencing greater emotional awareness and the development of authentically "affirming" self-statements (Conrad Baars Institute, https://baarsinstitute.com/).

Several respondents wrote that they ask clients to "journal," especially about their "feelings and thoughts." Another recommends that clients write "a timeline for the life" and applying the "SPICE acronym (Spiritual, Physical, Intellectual, Communicative, Emotional)" to the events of their lives. The insights gained are then explored during therapy, and clients are guided to set future life goals. In an activity which also may happen during a therapy session, one respondent encourages clients "*to develop self-awareness by focusing on how they perceive themselves compared to the qualities of the person they are attracted to."* He explains that *"this usually helps them to see that SSA is not about the other person, but about their own deficits in self-esteem."*

Finally, one respondent reported:

> *I highly recommend that my male clients get a mentor, coach, or personal trainer so that they can experience firsthand what it's like to have another male interested and invested in them and in their well being. [And g]etting connected to their own male bodies helps eliminate the need to get connected to other men's bodies.*

And, another wrote: "*For those who are interested and feel ready, social skills training/coaching around how to navigate initial dating experiences with the other sex are needed*" and recommended.

When Serving Clients with SSA Who Do Not Seek to Change

One respondent wrote about the influence of his faith on how he tries to help a client with SSA who is not seeking professional help to change their attractions or behavior:

> *My faith instructs me to respect the free will of my clients, much like how our heavenly Father respects our freedom to choose to do good or evil acts. If my client wants to act on his SSA and prefers not to work on reducing his SSA, then I can respect his free choice to do that. . . . While I might respect his free choice to sin, my brain does not fall out. The Catholic view that homosexual sexual acts are evil provides a helpful structure with which to view whether or not a client is making a prudent decision. To choose evil is harmful to oneself and others, especially in the case of choosing to engage in homosexual acts. Secular viewpoints that either have no opinion on the morality of the act or encourage objectively immoral behavior are sadly lacking in comparison to what the Catholic faith has to offer in this area. While I respect a client's choice to sin, I do not rejoice in it, but instead, I feel love and sadness for the client.*

In a statement which may not be accepted with those who try to "normalize" SSA or other unchaste religious practices, one respondent wrote: "*Data from sociologist Mark Regnerus, Ph.D. and other such research is shared slowly to show the detriment of a homosexual lifestyle*." And for therapists of any or no faith practice who do not accept the Catholic standards for sexual morality (see Sutton, 2019), another respondent's comments are likely challenging: "*The Catholic faith provides a framework for acceptable and unacceptable therapeutic interventions."* For example, according to Catholic Church teaching, it is not morally acceptable for therapists to use in therapy or prescribe for use outside the practices of pornography or "*masturbation*."

When Serving Clients for Any Reason, Including SSA

Regardless of whether clients practiced any particular faith or no faith, many respondents emphasized that at a minimum, they practiced psychotherapy—or their respective medical specialty—in a "personal" way. They try to serve the wellbeing of each client as a "person"—not a "sexual orientation" or unwanted "problem"—one at a time. Respondents described their faith as a resource for being able to serve better their clients with SSA. For example, one wrote: "*My Catholic faith helps me in that everyone deserves to be loved. Love meaning being kind, patient and embracing the truth*." Another wrote about trying to treat clients "*as treasured children of God*" whatever they may believe or do faith-wise. A third remarked: *"[M]y faith also helps me to be attentive to and compassionate towards the suffering of these clients, no matter how they see themselves or what they have done."*

In general, respondents emphasized that they serve clients "*where they're at*" at the moment, with the best of their professional knowledge and education. In the words of one respondent: *"Whatever foundational spiritual or philosophical beliefs the patient has. I have to use their definition of normal to treat them. I try to augment it with education if possible."* Another described his efforts to "do one without neglecting the other":

> *[I] in general, my therapeutic efforts do not differ. . . . Sometimes, I would go beyond the love/support/ compassion for one's self—i.e. root this compassion in the person and presence of Jesus in the patient's heart—that is possible only with Christian believers. My faith helps me to be benevolent and patient with my patients on the one hand, and face the objective situations of suffering which cannot be changed in their life without losing hope (on the other).*

In *my* words, respondents have found that they can be faithful "brothers and sisters in Christ," in themselves and to their clients, as they serve the latter as healthcare professionals. In fact, they have found that living their faith enhances their ability to best serve those who come to them for care.

Concluding Comments

Limitations of the Study

The present study has all of the limitations of a "convenience" sample, and more. The respondents were not "selected" in a manner which hopefully would elicit a "representative" sample of the population of "Catholic mental and medical healthcare professionals." Rather, the respondents comprise but a collection of persons known to me—or one of the respondents—selected because I believed both that they are practicing and devout members of my own Catholic faith and that they have found their faith to be a positive resource and guide for their practice of their particular medical and mental healthcare professions. I do not claim that this sample's responses generalize to all Catholic healthcare professionals, let alone those who serve persons with unwanted SSA. But I do think that these fourteen respondents provide a fair example of how dedicated and ethical Catholic therapists and physicians try to serve clients of various and no religious faiths who want professional help dealing with unwanted SSA. A few final generalizations based on these respondents follow.

"First, Do No Harm"

All healthcare professionals are committed to the ethical principles of their professions (American Association of Marriage and Family Therapy, American Counseling Association, 2014; American Psychiatric Association, American Psychological Association, 2017; and National Association of Social Workers, 2017). The first, most important, principle is "Do no harm!" (nonmaleficence), which is followed by the second: "Do as much good as you can!" (beneficence). In this light, all professionals who serve persons with SSA must be aware of and concerned that some SSA behaviors and co-occurring difficulties involve significant medical—and sometimes mental health—risks.

Medical and mental health reports show that whether their homosexuality (SSA) is wanted or unwanted (ego-*syntonic* or *dystonic*), persons with SSA seek psychiatric and psychotherapeutic care for a variety of concerns. These include mood difficulties (e.g., anxiety, depression, bipolar); post-traumatic stress (e.g., emotional, physical and sexual abuse); past and current relationship difficulties, often influenced by family of origin and school or other peer-based experiences; substance use and behavioral addictions; and medical concerns related to the SSA lifestyle (e.g., sexually transmitted infections and anatomical injury). In general, the population of persons who experience SSA also experience such difficulties at significantly higher rates than those who do not (County of Riverside (CA), 2014; Cretella & Sutton, 2010; Diggs, 2002; Phelan et al, 2008; Ritter et al., 2012; Whitehead, 2010).

So, whether a client is *ego-syntonic* or—*dystonic* about his or her homosexuality, all healthcare professionals have a responsibility to properly educate clients about these risks. A respondent pediatrician offered the following as a summary of how her Catholic faith helped her "first do no harm" and better serve clients whom she learned were engaging in SSA behavior, but otherwise were not interested in stopping. She wrote:

> *While I practiced general pediatrics for 17 years, sexual minority youth came to me for their general physicals and sick visits. My Catholic faith helped me treat them with good medicine, honesty and compassion. Without my Catholic faith, I'd have "drunk the PC Kool Aid" and lied to them. Instead, I was able to honestly offer "You know, some young women find their sexual attractions shift during teen years," or "Now that you are in therapy for your sexual assault, do not be confused if your sexual feelings shift; this may happen," or "As you know, MSM are at extremely high risk of contracting HIV. Some MSM have successfully increased their heterosexual potential." Only 2 young men ever expressed unwanted SSA to me. One successfully sought therapy ten years ago at age 17 and is now engaged to marry a lovely young woman. The second was unable to find a therapist and he eventually moved away.*[7]

It is hoped that all mental and medical healthcare professionals, whether *they* practice any or no religious faith, including those who are "gay-affirmative," offer all clients with SSA—whether *ego-syntonic* or -*dystonic*—the care offered by this pediatrician.

Do as Much Good as You Can

As mentioned above, when asked how they would respond to clients who reported practicing a different or no religious faith, the professionals' consistent response was that they would just try to serve them "as therapists." As mentioned above, persons with SSA, unwanted or not, may experience one or more difficulties with which they only or also want to be helped. Simply providing "good (enough) care" to such clients will allow and require therapists and physicians to help them to deal with a number of difficulties.

In reviewing the major bio/psycho/social experiences and conditions which commonly are co-morbid or co-occur with SSA, I summarized that

> the presence of SSA suggests the need for working on . . . unmet needs, unhealed hurts, unresolved [unfelt & undealt with] feelings, unrealized growth and maturation, unreconciled relationships, unclear boundaries, unrealistic hopes, fears and expectations, an unfulfilling—and inauthentic—self-image/identity, and unmanaged co-occurring (co-morbid) difficulties. (Sutton, 2014, p. 70)

[7] Internist John Diggs, MD (2002) offers similar wisdom concerning the need for professionals to "first do no harm" when serving persons known to be engaging in homosexual behaviors by warning about the risk of harm they may face through engaging in specific behaviors and offering guidance about dealing with them:

> As a physician, it is my duty to assess behaviors for their impact on health and wellbeing. When something is beneficial, such as exercise, good nutrition, or adequate sleep, it is my duty to recommend it. Likewise, when something is harmful, such as smoking, overeating, alcohol or drug abuse, and homosexual sex, it is my duty to discourage it. (Executive Summary)

Many different therapeutic approaches and techniques have been developed for helping clients try to resolve such issues. Professionals with little or no prior experience serving clients with SSA, but who have learned even one way to serve even one of these needs with clients of any kind, can be confident that they have something important to offer clients with SSA too.

Lambert's (2013b) review of the outcome research on the efficacy and effectiveness of psychotherapy supports this perspective. Lambert emphasizes that after several decades of attempts, research shows that the most significant factors which facilitate therapy clients' improvement are *not* the therapeutic approaches or techniques—including "empirically supported" therapies—which are used. Rather, what stimulates "patient improvement" the most is the quality of the "positive affective relationships" and "positive interpersonal encounters" between the therapist and patient which occur.

As Lambert summarizes:

> [H]elping others deal with depression, anxiety, confusion, inadequacy, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship that is characterized by trust, understanding, acceptance, kindness, warmth and human consideration. . . . This is not to say that techniques are irrelevant but that their power for change is limited when compared with personal influence. (p. 206)[8]

Be a Professional, Catholic "Witness"

Being a "witness" means two things: telling others what one has seen, heard, and experienced. And, by "walking one's talk," showing by one's example what one believes. For Catholics, "witness" is another name for "martyr, of which the Church recognizes two "kinds": red and white. All Christians are called to be "white" martyrs," to be men, women, and youth who "witness the Gospel," i.e. live lives of faith, with and through "heroic virtue." "Red martyrs" are those who were or are killed because they were living lives of heroic witness. In different ways, the professionals who responded to my questionnaire are witnesses, of both their professions and their faith.

In his 1974 address to the Roman Catholic Council on the Laity, Pope Paul VI (1974) emphasized the importance in society today of having "witnesses" of whatever truths are being proposed. He stated: "Modern man listens more willingly to witnesses than to teachers, and if he does listen to teachers, it is because they are witnesses" (p. 68; 1975, n. 41). In the present day, I think that witnesses of the Catholic faith—and all faiths—who also are mental and mental healthcare professionals, are called to be witnesses of "nonmaleficence" and "beneficence" (cf., APA, 2017) with their clients.

I believe that this sample of professionals offers an important "witness" to their similarly practicing and devout Catholic clients, in ways described above. I believe that these professionals also witness to non-Catholic clients, and also to other professionals, whether Catholic, Christian,

[8] Lambert adds, "Common factors that help explain [a client's] improvement in therapy also include exposure to anxiety-provoking situations, and encouragement to participate in other risk-taking behavior (i.e., facing reality and problem-solving) rather than avoiding the difficult and painful" (p. 206).

and of other or no religious faith. These respondents offer an important message to anyone who strives to be a sincere "seeker of the truth" and person of "good will" as a mental or medical healthcare professional. Any therapist or physician who genuinely wants to serve at least the "temporal"—if not the "eternal"—well-being of persons who experience SSA—whether wanted or not—would do well to develop one or more of the attitudes expressed by the respondents.

It can be challenging simply trying to serve others professionally the best that one can, and even more so trying to serve others whose faith practices differ from one's own (cf. the ethical principles and practices for the mental and medical healthcare professions: AAMFT, 2015; ACA, 2014; American Psychiatric Association, 2013; American Psychological Association, 2017; NASW, 2017). The current cultural-political climate makes serving clients with unwanted SSA even more challenging. But trying to do so by Catholic professionals requires them to be genuine witnesses of and to both their fellow professionals, as well as to their fellow Catholics and persons of other Christian, non-Christian and no religion. For all of the variety of special ways—described above—in which Catholic professionals may serve persons with SSA, in the end, the professionals see their goal as simple, but not easy.

One respondent wrote that for clients without religious faith,

> *it is best to avoid any reference to religion. It is NOT helpful to use religion to establish boundaries; rather, it is better to underscore the consequences of certain actions to bring about a change of behavior. Specific therapeutic theories/interventions/modalities remain the same*.

When considering serving clients of one's own, a different, or no faith, another respondent wrote: "[*My faith*] *helps me see them as precious souls with an eternal destiny worthy of great love and compassion*." A third stated that he simply tries to "[*t*]*reat them as treasured children of God*."

A fourth reported: "*My faith helps me to be benevolent and patient with my patients on the one hand, and to face the*[*ir*] *objective situations of suffering which cannot be changed in their life without losing hope*" on the other. Finally, one professional remarked that his faith is "*a constant reminder that I am 'small' and not God; He (Christ) and His Church are a constant source of guidance, confidence and trust. I'm also reminded that He has provided me with particular gifts"* to serve others. May all Christian professionals who serve persons with SSA—or any presenting concern—try to do the same!

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Appendix

Questions for Catholic Mental and Medical Healthcare Professionals Who Serve Catholic Clients with Unwanted Same-Sex Attraction and Behavior (SSA)

Philip M. Sutton, Ph.D.
April 28, 2019

1) How does your Catholic faith help you to better care for your clients with unwanted SSA?

2) What faith-related strengths do they have which help them to participate in and cooperate with your therapeutic and/or medical care?

3) In what way(s) may their particular practice of the faith tend to hinder—or otherwise make "riskier" or less effective—their participation in and cooperation with your professional care?

4) What specific professional and/or pastoral interventions/techniques have you found to be more/less helpful in serving your RC clients?

5) Please list any particular therapeutic and/or pastoral resources or activities which you recommend as "homework" for clients with unwanted SSA.

6) Please describe any "religiously sensitive clinical interventions," i.e. any psychoeducation, therapeutic techniques, or other professional and/or pastoral ways of serving your Catholic clients which some/many of them may find difficulty hearing—or heeding.

7) Under what circumstances would you collaborate and/or consult with Catholic clergy in caring for your client?

8) Under what circumstances would you advise your client to seek spiritual direction, sacramental care and/or other pastoral support from Catholic clergy?

<u>Background Information Questions</u>:

1) How old are you?

2) For how long have you been a Catholic?

3) In what mental and/or medical health-care profession(s) are you licensed?

4) How many years have you served persons with unwanted SSA?

5) On average, how many persons with SSA are on your active caseload?

6) What particular therapeutic orientations and interventions guide your professional practice serving all clients?

7) What particular therapeutic orientations and interventions guide your professional practice serving clients with unwanted SSA in particular?

If you have the time!

Questions about the influence of faith—yours and your clients—on your professional service to them:

1) Compared with serving Catholics, what specific professional and interventions/techniques have you found to be more/less helpful in serving your non-Catholic Christian clients with unwanted SSA?

2) Compared with serving Catholics, what specific professional and interventions/techniques have you found to be more/less helpful in serving your clients who report practicing a non-Christian religious faith?

3) Compared with serving Catholics, what specific professional and interventions/techniques have you found to be more/less helpful in serving our clients who report practicing no particular religious faith?

4) How does your Catholic faith help you to better care for all of your Catholic clients?

5) How does your Catholic faith help you to better care for all of your clients in general?

Critique of the *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009)

E. M. Friedman[1]

The Millennium Initiative, Cleveland, Ohio

In 2009 the American Psychological Association (APA) published a review of literature on homosexual sexual orientation change efforts (SOCE) entitled, "Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation", which concluded that such efforts are "unlikely to be successful." This critique investigated the studies that were cited by APA as the basis for their conclusion and found that a good many of the studies reported encouraging results from sexual orientation change efforts (SOCE) and did not concur with the conclusion of the APA authors. Additional problems with the APA report included the almost unanimous presence of homosexual members on the Task Force (6 out of 7 members), with the 7th member consistently aligned with pro-homosexual causes, along with numerous instances of data presented that were directly contradicted by study statistics. The APA authors also arbitrarily excluded scores of books and scientific studies favorable to SOCE that were authored during the 1960 to 2006 window of investigation utilized to compile the review. Given the increasing trend for states to ban SOCE even for men who desire it, the harm engendered by the issuance of a potentially biased report by the prestigious APA cannot be overstated. Based on the evidence presented, the critique ends with a call for a research misconduct investigation into the APA Task Force report.

Keywords: SOCE; 2009 APA Task Force; homosexuality; sexual orientation; research misconduct

The following paper is a critique of a report published by the American Psychological Association in 2009 entitled "Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation." This report has

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become the cornerstone of efforts to ban sexual orientation change efforts (SOCE) first with minors and more recently with adults, which have been steadily gaining support since California became the first state to ban the practice in 2012.

On the abstract page in the beginning of the Task Force report (2009), the APA authors, of which 6 of 7 were homosexual or lesbian[2], state the following:

> The American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual orientation conducted a systematic review of the peer-reviewed journal literature on sexual orientation change efforts (SOCE) and concluded that efforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates. Even though the research and clinical literature demonstrate that same- sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity, the task force concluded that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation.

A synopsis of the points included in the statement are as follows:

1. The APA task force conducted a systematic review of peer-reviewed literature on SOCE.
2. Efforts to change sexual orientation are unlikely to be successful.
3. There is a risk of harm in sexual orientation change efforts.
4. Research demonstrates that homosexual attractions, feelings, and behaviors are normal.
5. The population that undergo SOCE tend to be strongly conservative, religious, people.

This report focuses on the first three statements stated in the abstract and provides evidence that they are either untrue (statement 1), or are not supported by the conclusions of the studies reviewed in the report (statements 2 and 3). Statements 4 and 5 are outside the purview of this report.

Statement No. 1: The APA task force conducted a systematic review of peer-reviewed literature on SOCE

In a review of interventions historically used to facilitate sexual orientation change efforts, (SOCE), the Scientific Advisory Committee of the National Association for Research and Therapy of Homosexuality identified 7 main types of interventions:

- Psychoanalysis
- Behavior and Cognitive Therapies
- Group Therapies
- Hypnosis
- Sex Therapies
- Pharmacological Interventions
- Religiously Mediated Re-orientation

While the authors of the APA study claim to have done a systematic review of the scientific literature on SOCE, most of the studies presented in the report deal only with behavioral therapies, such as aversion and desensitization, and were predominantly

[2] https://www.josephnicolosi.com/collection/2015/6/11/who-were-the-apa-task-force-members

gleaned from one review of behavioral methods published by Adams and Sturgis in 1977 entitled "Status of Behavioral Reorientation Techniques in the Modification of Homosexuality: A Review." Statistics from this review are reported multiple times in Chapter 4 (pp. 35–43) of the APA report, and most of the studies reviewed in it are then mentioned individually in the same chapter. Of the 37 studies appearing in the Adams and Sturgis review, 29 were reviewed in Chapter 4 (see Appendix C). The APA authors, however, did not concisely summarize the outcomes as Adams and Sturgis did, but selectively chose what information to pass along about each study, which in many cases did not reflect the conclusions arrived at by the authors. In addition, they limited the scope of their report in the following ways:

- By utilizing the method of systematic review of peer-reviewed studies to compile their report, they excluded all books written on the topic of SOCE during the period under consideration in their study (1960–2006). Appendix A of this report provides a short list of 22 books or chapters of books dealing with SOCE that were published during this period but were not included in the APA report.
- They excluded many other behavioral-based studies that were not covered in the Adams and Sturgis review, and virtually all non-behavioral based studies that were published during the years of 1960 through 2006. Appendix B of this report lists the names and a brief description of just a small sampling of excluded studies.
- They arbitrarily chose the inclusion period of their review to begin in 1960, thereby excluding all information and studies on the subject that had been amassed beginning in the late 19th century up to 1959.

It comes out, therefore, that the APA

- relied heavily on the results of a short 15-page systematic review of behavioral therapies to compile a diffuse 140-page report, with the first 25 pages devoted to such topics as "The Impact of Stigma on Members of Stigmatized Groups," "Psychology, Religion, and Homosexuality," and the "Psychology of Religion";
- presented the report as a comprehensive review of peer-reviewed literature on SOCE, while actually reporting almost exclusively on behavioral studies;
- effectively doubled the results of the single review they relied on by reporting its statistics in the name of the study authors, then reviewing many of the studies contained in it individually in the same chapter;
- incorporated a variety of inclusion criterion which severely limited the pool of studies used to arrive at their conclusions; and
- selectively presented the results of the limited amount of studies they did review in a manner which did not accurately reflect the conclusions of the studies themselves. In some cases, false data was presented that was directly contradicted by study statistics.

In an article published online by Callan G. Stein (2014), a partner in the Health Sciences Department Practice Group of Pepper Hamilton LLP entitled, "What Is Research Misconduct and Why Should I Care?" the following statement appears regarding research misconduct:

> It is a common misconception that one must make up research data or results to commit research misconduct. Such conduct (known as "fabrication") is a common form of research misconduct but it is not the only form. One also commits research misconduct by presenting true data/results in a misleading manner. This form of misconduct (known as "falsification") does not involve

> making up data or results and is, instead, often achieved by unduly emphasizing one portion of data over another or omitting data altogether.

The author also states the following regarding minor errors that do not require a retraction:

> Unlike intent, materiality is not a required element for establishing research misconduct. Therefore, whether the error is significant enough to warrant a retraction of the paper/publication is immaterial to the question of whether research misconduct occurred. . . .

Along with erring repeatedly regarding details of the studies they reviewed, the APA authors engaged in multiple acts of both fabrication and falsification throughout Chapter 4, the outcomes chapter of their review (pp. 35–43). This critique deals mostly with fabrication, i.e erroneous data, and examines only Chapter 4, which comprises 9 out of 140 pages of the report. An expanded version is available upon request, which lists many examples of falsification as well, perpetrated by the APA authors in this chapter. Further scrutiny of the entire report, however, will be required to uncover the full extent of inaccuracies present in the APA report.

Statement No. 2: Efforts to change sexual orientation are unlikely to be successful

The APA authors came to this conclusion in spite of the fact that the Adams-Sturgis review (1977), which served as the basis for their report, reported that

> seventy-two percent of the subjects in the group studies have shown improvement in at least one category, whereas 85% of the clients treated in the single-case design have demonstrated such improvement. (p. 1184)

and

> Although the current status of sexual reorientation procedures as clinical techniques for modifying sexual preferences is not overwhelmingly positive, there are indications that, as the sophistication of the conceptualizations and treatment procedures increases, more significant results are achieved. (p. 1185)

and

> The foundations for an effective treatment procedure have been laid; however, the building of sturdy walls is a much slower process. Nevertheless, each component added to the structure moves the clinician closer to the eventual goal of building an effective and dependable treatment procedure. (p. 1186)

In the eight places the Adams-Sturgis review was quoted in Chapter 4 of the APA report, none of the above statements were reported or summarized. These statements, along with the positive conclusions of many of the studies reviewed in the APA report, call into serious question the APA conclusion that "efforts to change sexual orientation are unlikely to be unsuccessful."

In addition to the above statements that were not at all reported in the APA review, the following are examples of data that were reported in an incomplete or erroneous fashion from the Adams-Sturgis review. Each statement of the APA is followed by a comment critique, which identifies where the

APA authors falsified, fabricated, or erred in reporting data.

On page 37 of the APA report in the section entitled "Decreasing Same Sex Sexual Attraction—Non-Experimental," the following comment appeared:

> H. E. Adams and Sturgis (1977) reported that in the nonexperimental studies in their review, 68% of 47 participants reduced their same-sex sexual arousal compared with 34% of participants in experimental studies.

This comment is incorrect. Nowhere in the Adams-Sturgis review do the authors report that 68% of 47 participants in non-experimental (i.e. uncontrolled) studies reduced their same-sex sexual arousal. The only way to arrive at a figure of 68% of 47 participants who reduced same-sex arousal is to add together 18 of 23 participants from non-experimental, (uncontrolled) single case studies (Table 3, p. 1178) with 14 of 24 participants from experimental (controlled) single case studies (Table 4, p. 1181), which yields a figure of 32 of 47 or 68%. Thus, the figure of 68% of 47 participants who reduced their same-sex sexual arousal was compiled by adding together participants in non-experimental single case studies with those in experimental single case studies, and not from non-experimental studies alone, as reported in the APA report. The APA authors computed this percentage on their own and falsely reported it in the name of the study authors.

Furthermore, the above comment of 68% of 47 participants is preceded by the following statement:

> As is typically found in intervention research, the average proportion of men who are reported to change in uncontrolled studies is roughly double the average proportion of men who are reported to change in controlled studies. (p. 37)

A constant theme throughout the APA review is the questionable assumption that nonexperimental studies, as opposed to experimental ones, "lack sufficient rigor to access efficacy," and are only "useful in identifying potential treatment approaches." While there is no way to know for sure how or why the above mistake occurred, one possible explanation is that by falsely grouping the information in this fashion (68% non-experimental vs. 34% experimental), the APA authors were able to show an example where non-experimental studies produced twice as many successful statistics as experimental studies, thereby validating their theory.

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- Comment on page 38 of the APA report regarding the percentage of participants reporting decreased homosexual behavior after SOCE:

> In their review, H. E. Adams and Sturgis (1977) found that across the seven controlled studies published between 1960 and 1976, 18% of 179 subjects in these studies were reported to have decreased same-sex sexual behavior. . . .

Comment critique: The statistic of 18% of 179 participants in 7 controlled studies is erroneous. The APA authors did not factor in results from 11 controlled single case studies reported in Table 4 on p. 1181 in the Adams-Sturgis review. This table shows that 13 of 24 patients in controlled single case studies reduced homosexual behavior after treatment. Factoring in these figures to the 18% of 179 cited by the APA authors brings the total patients who decreased homosexual

behavior in controlled studies to 46 of 203 or 23%—an increase of 5%.

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- Comment regarding the percentage of participants reporting increased heterosexual behavior after SOCE (p. 40):

> According to H. E. Adams and Sturgis (1977), only 8% of participants in controlled studies are reported to have engaged in other-sex sexual behavior following SOCE.

Comment critique: This APA statement was gleaned from Table 2 on page 1176 of the Adams-Sturgis review. In the increased heterosexual behavior column (HeB), only 3 of 7 studies contributed statistics to comprise the total of 14 of 179 or 8% improved patients. In the other 4 studies, the study authors were unable to discern how many patients improved in this category for a variety of reasons (see Table 2 footnotes). They allude to this fact by using the greater than or equal sign in the total figure of 14, signaling that the actual figure may be higher. The APA authors failed to note that the figure of 8% was based on a greater than or equal to number of participants who increased heterosexual behavior after treatment and could be higher.

Furthermore, Table 4 on p. 1181 lists 11 controlled "single case" studies of which 11 of 24 patients, or 46%, improved in the heterosexual behavior category. The APA authors did not include data from these controlled studies in arriving at the 8% figure in the above statement. Adding 11 of 24 improved patients to the figure of 14 of 179 would yield a total of 25 of 203 or 12% improved patients in controlled studies in the heterosexual behavior category.

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- APA comment regarding previous heterosexual experience of participants in all studies (p. 40):

> From the data provided by H. E. Adam and Sturgis in their 1977 review, 61%–80% of male research participants appeared to have histories of dating women, and 33%–63% had sexual intercourse with women prior to intervention.

Comment critique: The above percentages reported by the APA authors are false and are directly contradicted by the following statement that appeared on p. 1184 of the Adams-Sturgis review:

> . . . It appears that a minimum of 45% had some heterosexual dating history and 30% had attempted heterosexual coitus in the past. These are minimal incidents estimates, since the incidence of these activities could not be determined in many studies. . . .

While the study authors did state minimum estimates, there is no way for the APA authors to have interpolated higher percentages from the data in the Adams-Sturgis review because the study authors themselves state that "incidence of these activities could not be determined in many studies . . ."

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The following studies, which were also reviewed in the APA report, provide further examples of misconstrued, omitted, or altered data. The abstracts presented for each study did not appear in the APA report, but were gleaned by the authors of this critique to contrast what the APA authors reported about

the study, to what the study authors actually reported.

Study name: Classical, Avoidance, and Backward Conditioning Treatment of Homosexuality (McConaghy & Barr, 1973)

What the study reported

Forty-six patients were randomly allocated to receive aversion therapy for homosexual impulses according to a classical, avoidance, or backward conditioning paradigm. . . . Three weeks after treatment, the patients showed significantly less penile volume increase to the pictures of men and less penile volume decrease to the pictures of women; but no penile volume increase to the pictures of women. . . . At one year following treatment approximately half the patients reported a decrease in homosexual feeling and half an increase in heterosexual feeling. Approximately a quarter reported an increase in heterosexual intercourse and a quarter a cessation of homosexual relations.

What the APA reported about the study

APA comment (p. 38) regarding decreased homosexual behavior after SOCE:

> McConaghy and Barr (1973) reported that 25% of men had reduced their same-sex sexual behavior at 1 year.

Comment critique: In Table 2 (p. 155) the study authors report that 15% (7 out of 46) of participants reduced homosexual relations, and 26% (12 out of 46) stopped all homosexual relations at one year follow-up. The APA authors wrongly reported that 25% reduced homosexual behavior when in fact 15% reduced homosexual behavior and 26% ceased all homosexual relations (as stated in the abstract), for a total of 41% who reduced or completely stopped homosexual behavior.

APA comment regarding increased heterosexual behavior (p. 40):

> Among those studies we reviewed, only 2 participants showed a significant increase in other-sex sexual activity. (McConaghy & Barr, 1973; Tanner, 1974)

Comment critique: This statement is false. The abstract clearly states that approximately 25% of 46 or 9 patients increased heterosexual intercourse in this study alone. Furthermore, the study authors did not discuss the extent of increase in individual patients, so the word significant is in error.

In the Tanner 1974 study, the authors did not report the number of patients in the experimental group who improved but gave the percentage of change for the group as a whole (see Table 1, p. 31). The APA authors, therefore, could not have gleaned the number of participants who improved from the information given by the study authors.

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Study name: Avoidance Conditioning for Homosexuality (Birk et al., 1971)

What the study reported

An avoidance conditioning technique for homosexual men developed by us was subjected to controlled clinical testing, with long-term (two-year) follow-up. In five of eight treated patients and in none of eight placebo-treated patients, homosexual response suppression was produced. . . . Conditioning treated patients were significantly more improved than placebo-treated patients in terms of sexual behavior change ($P = 0.001$). Successfully conditioned patients reported absence or marked diminution of homosexual feelings as well as of overt homosexual behaviors. Even though booster conditioning treatments were not

used, two of eight patients achieved sustained happy heterosexual adjustments.

What the APA reported about the study

APA comment regarding decreased homosexual attraction in this study (p. 36):

> Birk et al. (1971) found that 5 (62%) of the 8 men in the aversive treatment condition reported decreased sexual feelings following treatment; one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up.

Comment critique: The APA comment states that patients "reported decreased sexual feelings," which indicates both homosexual and heterosexual feelings, when the abstract clearly states that "homosexual response suppression was produced," and not heterosexual response.

Furthermore, the APA comment that "one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up" is false and is directly contradicted by the following statement which appeared on page 322:

> In assessing the practical clinical value of this technique then, one cannot overlook the fact that two of eight patients treated with "real" conditioning benefited directly and substantially, a shift from a Kinsey homosexuality of six to hetero-sexuality beginning during the conditioning, and enduring over time (follow-up now is 3 ½ years).

The shift from a Kinsey homosexual rating of 6 to a rating of heterosexual for both of these patients included reduction in homosexual arousal for 2 out of 8 patients or 25%, and not 1 out of 8 or 12% as stated by the APA authors.

APA comments regarding 2 patients who received long-term benefits from treatment in this study and married after SOCE:

- Birk et al. (1971) found that two of 18 men (11%) had avoided same-sex behavior at 36 months (p. 38).
- Birk et al. (1971) found no difference between their treatment groups in reported sexual arousal to women. Two men (11% of 18 participants) in the study reported sustained sexual interest in women following treatment (p. 39).
- Birk et al. (1971) found that 2 of 18 respondents (11%) were married at 36 months (p. 41).

Comment critique: This study was divided into two groups of 8, with one group receiving treatment and the other not. The APA authors incorrectly included the placebo group and two participants who dropped out early to arrive at their figure of 18 participants when in fact only 8 participants received treatment, as clearly stated in the abstract. The placebo group should not have been included in arriving at percentages of change for participants as a result of treatment. The APA authors made this error in spite of stating the correct number of participants receiving treatment in their comment above on page 36.

Furthermore, these three comments provide a clear example of how the APA authors needlessly spread data from individual studies throughout their report instead of transmitting study results in a concise fashion. Transmitting the data in this fashion both diluted the impact of the results and made it appear that many more studies had been reviewed than actually were.

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Study name: Treatment of Homosexuality: II. Superiority of Desensitization/Arousal as Compared with Anticipatory Avoidance Conditioning: Results of a Controlled Trial (James, 1978)

What the study reported

A comparative trial of two therapies for treatment-seeking homosexuals was undertaken. . . . From their history and also their scores on a sociosexual anxiety rating scale, patients were classified as heterophobic (heterosexual anxiety) or non-heterophobic. . . . Thus, there were four subgroups: (a) heterophobes receiving desensitization, (b) heterophobes receiving aversion, (c) non-heterophobes receiving desensitization, and (d) non-heterophobes receiving aversion. There were 10 patients in each subgroup. . . . A 2-year follow-up showed that both heterophobes and non-heterophobes responded better to desensitization than to aversion therapy.

What the APA reported about the study

APA comment in the section titled "Decreasing Same Sex Sexual Behavior," regarding the scope of this study (p. 38):

> S. James (1978) did not report on behavior.

Comment critique: This statement is false. The grading system in the James study covered all 4 aspects reviewed in the APA report: same-sex attraction, same-sex behavior, opposite-sex attraction, and opposite-sex behavior. Table 1 on p. 32 broke the statistics down and reported that at 2-year follow-up:

- 15% (6 out of 40) of all participants showed complete absence of homosexual fantasies, interest, and behavior; (along with) presence of heterosexual fantasies, attractions, and behavior up to (i.e. including) successful sexual intercourse.
- 10% (10 out of 40) of all participants showed almost complete absence of homosexual drives and beginning of heterosexual behavior although not having heterosexual intercourse.
- 12.5 % (5 out of 40) of all participants showed no homosexual behavior, and occasional homosexual fantasy, or attraction; the beginning of heterosexual behavior and heterosexual attractions and fantasies predominating.
- 22.5% (9 out of 40) showed slight improvement, such as increase in heterosexual interest and some diminution in homosexual interest.

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Study name: The Extinction of Homosexual Behavior by Covert Sensitization: A Case Study (Curtis & Presly, 1972)

What the study reported

Case study: "The patient was a 31-year-old, intelligent, self-employed male with history of homosexual behavior extending over 7 years. . . . No homosexual contacts were made during the period of treatment, which lasted for two months, although the wish to do so arose occasionally. Follow up in the four-month period since treatment has confirmed the patient's complete abstinence, both in fantasy and reality.

The main consequences of the eradication of this patient's homosexual behavior have been an improvement in his marriage through a lowering of "tension" and a feeling of "inner calm."

Sexual relations with his wife have improved and there has been a general heightening of interest in the opposite sex" (p. 407).

". . . At the first interview the patient completed the Sexual Orientation Method Questionnaire. . . A score of 48 is the maximum in both instances. The patient on this occasion scored 48 for heterosexual interest, and 33.5 for homosexual interest" (p. 408).

". . . At the end of treatment, a second orientation questionnaire was completed; scoring on this occasion was heterosexual interest: 46.5; homosexual interest: 8" (p. 409).

What the APA reported about the study

APA comment regarding the results of treatment in this study (p. 37):

> Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items.

Comment critique: This comment is both incomplete and grossly misleading. It is incomplete because the abstract reports complete abstinence from same-sex behavior at 4-month follow-up, whereas the APA comment only reports reduced but not complete abstinence from same-sex interest had occurred.

It is grossly misleading because the abstract reports that sexual relations with the patient's wife improved and that he showed "a general heightening of interest in the opposite sex"; whereas the APA comment reports that the patient showed "reduced other-sex interest." They deduced this from the before and after questionnaire results but do not report that the drop was statistically insignificant (48 to 46.6). They also say nothing about the clearly stated conclusion of the study authors that other-sex interest in the patient had increased. By refraining from mentioning the conclusion of the study authors and focusing on a statistically irrelevant fact, the APA authors were able to cover up the fact that treatment had reduced homosexual behavior and increased heterosexual functioning in the patient.

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Study name: Overt Male Homosexuals in Combined Group and Individual Treatment (Mintz, 1966)

Study type: Psychotherapy/combined group and individual

What the study reported

Of 10 homosexual men who voluntarily entered treatment and remained in combined therapy for 2 or more years, all report improved general adjustment. Three reported satisfactory heterosexual adjustment; three hope to achieve it eventually. . . .

The homosexual men on whom these observations were made over an 8-year period consisted of 10 patients who remained in treatment with the writer for at least 2 years. . . .

Five of these men have terminated treatment. Of these:

- two have accepted themselves as homosexuals
- two are enjoying heterosexuality and report freedom from conflict
- one is still in conflict and may reenter treatment.

Of the five men still in treatment:

- one has lost interest in homosexuality and enjoys satisfying heterosexual relationships

- one does not intend to change his homosexual adjustment
- three appear to be moving toward heterosexuality, but with considerable anxiety and conflict (pp. 193–194).

What the APA reported about the study

APA comment regarding the results of the patients in this study (p. 37):

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

Comment critique: The APA authors mistakenly reversed the findings in this study and quoted the results of those who terminated treatment under the heading of those who remained. They also reported that 2 of these patients were "free from conflict regarding same-sex sexual attractions" but did not report that they were "enjoying heterosexuality."

Additionally, the description of the men who left the study as having "dropped out" is imprecise and misleading. All ten men completed a minimum of two years of therapy as stated clearly in the abstract, with 2 of the 5 who terminated treatment, "enjoying heterosexuality and freedom from conflict" as stated above. These men completed treatment successfully and then terminated it after it had achieved its goal. The term dropping out connotes leaving treatment prematurely and was not used by the study authors but was used by the APA authors.

- - -

Study name: Group Psychotherapy for Men Who Are Homosexual (Birk, 1974)

Study type: Group psychotherapy

What the study reported

Of the 66 patients in this series, almost half made heterosexuality an explicit treatment goal and remained in group therapy for 1 ½ years or more. Of these, 85 percent experienced at least partial heterosexual shifts and 52 percent striking, nearly complete heterosexual shifts.

Figure 8 summarizes in percentages the levels of heterosexual shift for the 27 patients who remained in therapy long enough (1 ½ years or more) to achieve near-maximal therapeutic results. The bar graph on the far left indicates that 23 out of 27 (85%) showed some evidence of heterosexual shift during therapy. The next bar graph shows that 14 out of 27 (52%) evinced a marked heterosexual shift during therapy, and the next shows that 17 out of 27 (63%) began having hetero-sexual intercourse during therapy. The bar graph on the far right shows that 10 out of 27 (29%) are now married (p. 41).

Addendum: This paper was originally presented at the Cornell Symposium on the Treatment of Sexual Disorders in January 1973. In the 20 months since then, there have been a total of 9 more heterosexual shifts (6 of these from the original series of 66) and 3 more marriages, all from the original series (p. 51).

What the APA reported about the study

APA comment regarding the number of participants who dropped out of the study (p. 37):

> Birk (1974) assessed the impact of behavioral therapy on 66 men, of

> whom 60% (n = 40) had dropped out of intervention by 7 months. Among those who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

Comment critique: Firstly, this study utilized group psychotherapy as stated in the title and not behavioral therapy as stated by the APA authors.

Secondly, the statement regarding 60% dropping out of treatment at 7 months is false and is directly contradicted beginning on page 39 where the authors discuss group therapy outcome data for the complete group of 66 patients. Of these patients, 53 were treated by male-female co-therapists, and 13 by a male therapist working alone. On page 40, the authors discuss the loss rate during the first 6 months of treatment for both groups and state:

> In figure 7, the bar graphs show a time-matched loss rate for the first six months of therapy under the two different conditions. Though the N is very small for such a time-matched sample, the contrasting trends are striking: the loss rate with male-female co-therapy was only 5 percent, while with solo male therapy the loss rate was 33 percent.

Thus, we see that 33% of 13 or 4 participants treated by a single male therapist, and 5% of 53 or 3 participants treated by male-female co-therapists, dropped out of intervention at six months for a total of 7 of 66 or 11%, and not 60% at seven months as reported by the APA authors.

APA comment regarding the number of participants who married in this study (p. 41):

> Two uncontrolled studies (Birk, 1974; Larson, 1970) indicated that a minority of research participants ultimately married, though it is not clear what role, if any, intervention played in this outcome.

Comment critique: On page 38, the study authors state the following:

> . . . The three bar graphs on the left show treatment results for those patients who remained in therapy for 2 ½ years or more, while the three bar graphs on the right show the corresponding outcome figures for those who remained in treatment for at least a year, but less than 2 ½ years. Thus, of the persevering subgroup of patients, 10 out of 13 (77%) shifted to or toward heterosexuality during treatment; 8 out of 13 began having heterosexual intercourse during treatment; and *6 out of 13 are now married as a result of treatment*. (emphasis added)

The conclusion of the study authors that 6 out of 13 patients married as a result of treatment is contradicted by the APA authors who state that "it is not clear what role, if any, intervention played in this outcome."

Secondly, as the abstract and statements from the author shows, this study reported some very impressive success percentages, yet the APA authors did not report any of them in their review.

Statement No. 3: There is some risk of harm in sexual orientation change efforts

In the section entitled "Reports of Harm" of the APA report (pp. 41–42), the next 6 studies were brought as evidence for the following

conclusion the APA authors drew in the abstract:

> [E]fforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates.

Examination of these studies will show that save for one possible exception (Quinn, Harbison, & McAllister, 1970), none of the authors attributed harm to their treatment method. The review will also show that in all 6 studies, the APA authors either misrepresent through omission or alter some aspect of the results reported in these studies.

The first 2 of the 6 studies have been discussed previously in this report, and only APA comments relating to claims of harm contained in these studies will be presented in this section.

1. Classical, Avoidance, and Backward Conditioning Treatment of Homosexuality (McConaghy & Barr, 1973)

What the APA reported about the study

> In McConaghy and Barr's (1973) experiment, 1 respondent of 46 subjects is reported to have lost all sexual feeling and to have dropped out of the treatment as a result. Two participants reported experiencing severe depression, and 4 others experienced milder depression during treatment. No other experimental studies reported on iatrogenic effects. (p. 41)

Comment critique: The following statements were said by the study authors regarding any negative effects of treatment in this study:

> All patients received 14 sessions of treatment during the five days in hospital. . . . All patients completed the sessions of treatment in hospital. (p. 153)
>
> . . . One patient refused any booster treatments, as he had lost all sexual feeling, both heterosexual and homosexual subsequent to the initial treatment in hospital. At one-year follow-up his sexual feelings had returned to their state before treatment. Apart from this patient's response there were no complications which could be attributed to the treatment. In the year following treatment two patients experienced fairly severe depression, and four others had episodes of milder depression. All six had had many similar episodes in the past. Their reactions could not be regarded as "symptom substitutions," as all showed minimal response to treatment. (p. 153)
>
> In the present and the two previous studies there has been no evidence of a significant disturbance of general behavior in patients treated with aversion therapy. (p. 161)

Based on these statements, the APA authors misstated or omitted results in the following ways:

1. They stated that one patient dropped out of the treatment due to loss of sexual feelings when he actually completed treatment but just refused booster treatments. They also fail to report that his sexual feelings returned at one year follow-up.
2. They stated that 6 patients reported severe and mild depression during treatment when the second comment above states that

these incidences occurred in the year following treatment.

3. They did not report that all 6 patients who suffered depression had many similar episodes in the past.

4. They did not accurately transmit the opinion of the study authors that save for one patient, "there were no complications that could be attributed to the treatment," and "in the present and two previous studies there has been no evidence of a significant disturbance of general behavior in patients treated with aversion therapy."

2. Aversion Therapy of Homosexuality: A Pilot Study of 10 Cases (Bancroft, 1969)

What the APA reported about the study

> In the study conducted by Bancroft (1969), the negative outcomes reported included treatment-related anxiety (20% of 16 participants), suicidal ideation (10% of 16 participants), depression (40% of 16 participants), impotence (10% of 16 participants), and relationship dysfunction (10% of 16 participants). Overall, Bancroft reported the intervention had harmful effects on 50% of the 16 research subjects who were exposed to it. (p. 41)

Comment critique: Firstly, the APA authors incorrectly place the number of study participants at 16, even though the title of the study expressly says, "A Pilot Study of 10 Cases." Additionally, this comment is a complete misrepresentation of the stated opinion of the study's author regarding the safety of the study. Nowhere does the author use the term harmful effects nor state any percentages of participants experiencing negative effects. Nor did the author report that the intervention "had harmful effects on 50% of the 16 research subjects who were exposed to it." The APA authors compiled these percentages and falsely presented them as having been reported by the author. To the contrary, regarding the overall safety of the study the authors state:

> Also, although unpleasant, the treatment has been tolerated well, and in no case can the patient be said to be worse off as a result of it. . . . The directly unpleasant effects of treatment have not presented much problem, although clearly care is needed whilst treating patients already depressed or suffering from generalized anxiety. The most severe depressive reactions have occurred more as reactions to the changes following treatment than to the treatment itself, and as such are probably to be expected equally with other methods. (p. 1428**)**

3. Case of Homosexuality Treated by Aversion Therapy (James, 1962)

Study type: aversion therapy

What the APA reported about the study

James (1962) reported symptoms of severe dehydration (acetonuria), which forced treatment to be suspended (p. 42).

Comment critique: This statement is disproved by the following description of the treatment method used in this study:

> Treatment was carried out in a darkened single room, and during this time no food or drink other than the prescribed alcohol was allowed. At regular two-hourly intervals he was given an emetic dose of apomorphine by injection followed by 2 oz. (57 ml.) of brandy. . . . Thereafter a tape

> was played twice over every two hours during the period of nausea. . . . After 30 hours the treatment was terminated because of acetonuria, and the patient was allowed up and about. After a period of 24 hours the treatment was restarted with another tape, which concentrated more wholly upon the effect his practices had had on him, again ending histrionically. Again the treatment was stopped because of acetonuria, this time after 32 hours. . . . On each of the third, fourth, and fifth days after the apomorphine treatment had finished a card was placed in his room, pasted on to it being carefully selected photographs of sexually attractive young women. (p. 769)

Thus, we see that treatment was not suspended because of acetonuria, but rather, extremely long sessions of fasting were continued until acetonuria occurred, then repeated after a period of 24 hours of rest. This process continued until 5 treatments had been administered. Acetonuria, therefore, was the signal point upon which to halt each treatment session and not a side effect that caused treatment to be completely suspended as implied by the statement of the APA authors.

4. An Attempt to Shape Human Penile Responses (Quinn, Harbison, & McAllister, 1970)

What the study reported

A 28-year-old patient with a long history of homosexuality (Kinsey rating 5) was found on psychometric testing to be of superior intelligence and of relatively normal personality; he therefore received 35 sessions of anticipatory avoidance conditioning. Following treatment he described a great reduction in his homosexual interest but complained of anxiety and "black depression" when imagining or attempting heterosexual behavior. He received 10 sessions of desensitization to reduce this anxiety. Eighteen months later the patient showed increasing homosexual interest and complained that he was only free from anxiety and depression when he avoided heterosexual fantasy or behavior (p. 213).

In one session the patient became anxious and complained of his "black depression." This was associated with attempts to imagine coital penetration. He was instructed to approach this fantasy in a hierarchical manner and then successfully completed this fantasy without complaining of anxiety (p. 214).

What the APA reported about the study

Quinn, Harbison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety (p. 41).

Comment critique: In neither this study nor the next study by Thorpe was any mention made of nightmares as stated in the APA comment.

5. Aversion-Relief Therapy: A New Method for General Application (Thorpe et al., 1964)

What the study reported

A new technique named aversion-relief therapy is described. It appears to be suitable for general application in the field of neurosis and greatly simplifies the normal requirements of the treatment situation. Cases are presented in which the technique has been applied and the therapeutic results are so far encouraging.

Case 1 (p. 74)

Male homosexual aged 31. Admitted for treatment of a recurrent reactive depression.

He attributed all his present symptoms of anxiety, tension, and irritability to his sexual practices of which he was deeply ashamed. Results of psychological tests showed him to be highly anxious, his score on the MAS (Taylor, 1953) falling at the 98th percentile. . . . *In the course of treatment, the patient developed depression and various gastric ailments*. However he persisted and completed treatment because he felt it was doing him good and really changing his sexual orientation. . . . Also he was claiming great satisfaction from his heterosexual masturbation fantasies and from seeing and kissing his girlfriend. He soon felt confident enough to leave hospital. . . . On discharge psychological assessment showed a drop from the 98th to 88th percentile on the MAS. . . . His own assessment of the treatment was "I never think about homosexuals now and when I meet one, all I feel is aggression and disgust. On the other hand for the first time in my life I am considering sex with a woman as a possibility and an enjoyable one too."

Discussion:

It would appear that this method of treatment is an extremely effective way of producing a change in behavior. . . . In regard to neuroticism or anxiety measures before treatment there is no detectable relationship between these and response to treatment. Most of our patients were extremely anxious both clinically and psychometrically, as can be seen from the case details. Not only were they able to tolerate treatment but there was no evidence of exacerbation of symptoms.

What the APA reported about the study

Quinn, Harbison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety (p. 41).

Comment critique: This patient had a history of depression, anxiety, etc. and was originally admitted into the hospital for depression. As the case history states, the patient willingly continued treatment and ultimately benefited from it, yet this was not reported by the APA authors. No evidence of harm from the treatment was reported by the study's authors as stated explicitly in the discussion comment above, yet the APA authors included this study as evidence of harm from SOCE.

6. An Experimental Analysis of Feedback to Increase Sexual Arousal in a Case of Homo- and Heterosexual Impotence: A Preliminary Report (Herman & Prewett, 1974)

What the study reported

The subject was a 51-year-old male who reported a homosexual history dating from age 13. Homosexual activity was greatest during his mid-twenties, but he had never been able to maintain an erection for more than a few minutes and had ejaculated during only one encounter.

Discussion:

The results of the present study indicate that informational feedback can be used to systematically modify penile responding. . . . The increase in penile responding was paralleled by the achievement of ejaculation during masturbation, changes in masturbatory fantasy, and reports of homo- and heterosexual behavior outside the laboratory. However, approximately 7 months after discharge, the subject was readmitted to the hospital for medical complications following excessive drinking. He indicated that he had been "jilted" in a homosexual affair, attempted reconciliation, failed, and began to drink excessively**.**

What the APA reported about the study

Herman and Prewett (1974) reported that following treatment, their research

participant began to engage in abusive use of alcohol that required his rehospitalization. It is unclear to what extent and how his treatment failure may have contributed to his abusive drinking (p. 41).

Comment critique: The study clearly states that the reason for his excessive drinking was due to his having been jilted in a homosexual affair, yet the APA authors state it is unclear whether treatment failure caused the problem.

Conclusion

As stated above, this critique has examined only 9 of 140 pages (Chapter 4) of the APA report, and has focused mainly on fabrication (i.e. false data). A full research misconduct investigation is required to determine the total extent of errors, omissions, and falsifications that exist in the report.

Appendix A

The following is a partial list of scores of books or chapters in books, which deal with SOCE and its efficacy that were published during the period under consideration in the APA study (1960–2006) but were not included in that study.

Many of the book titles and their commentary were taken from a report entitled "What Research Shows: NARTH's Response to the APA Claims on Homosexuality" by The Scientific Advisory Committee of the National Association for Research and Therapy of Homosexuality (Phelan, Whitehead, & Sutton, 2009).

1. Bieber, T. B. (1971). Group therapy with homosexuals. In Kaplan & Sadock (Eds.), *Comprehensive Group Psychotherapy*. Baltimore, MD: Williams and Wilkins, 518–533.

Bieber reported a success rate of more than 40 percent through the use of group therapy.

2. Cappon, D. (1965). *Toward an Understanding of Homosexuality.* Englewood Cliffs, NJ: Prentice-Hall.

Cappon reported treatment outcomes of his clinical work with 150 patients using psychoanalytic-based treatments (including individual, group, and combined therapy). He found a 50-percent cure rate for homosexual men and a 30-percent cure rate for homosexual women. For those identified at the onset of treatment as bisexual, Cappon reported a 90-percent cure rate. After an average 20-month follow-up, only 10 percent lost part of their previous level of improvement and had to be reclassified or, when possible, treated further.

3. Feldman, M. P. & MacCulloch, M. J. (1971). *Homosexual Behavior: Therapy and Assessment.* Elmsford, NY: Pergamon Press.

Feldman and MacCulloch reported follow-up results on research done with 63 homosexual men between 1963 and 1965. They found that 29 percent of the men who had no prior heterosexual experience had changed. "Change" was indicated by ceasing homosexual behavior, having only occasional homosexual fantasies or attractions, and developing strong heterosexual fantasy, behaviors, or both.

4. Freund, K. (1960). Some problems in the treatment of homosexuality. In H. J. Eysenck (Ed.), *Behavior Therapy and the Neuroses.* Oxford, England: Pergamon Press.

Freund employed chemical aversion techniques to modify homosexual preference in 67 clients. Twenty of the clients were

excluded from the final report. With a 3- to 5-year follow-up, no improvement was observed in 60% of the cases, short-term improvement (decreased homosexual arousal) in 40% of the cases, and long-term success (3–5 years) in 25% of the total cases.

5. Glover, E. (1960). *The Roots of Crime: Selected Papers in Psychoanalysis,* vol. 2. NY: International Universities Press.

Glover discussed a series in which he treated 103 adults and 10 juveniles, with the duration of treatment varying from five months to five years. In seven cases, hormone treatment was used, either with or without psychotherapy. In terms of successful outcomes, 44 percent of the exclusively homosexual patients showed no further homosexual impulses after treatment, and 51 percent of the bisexuals lost all of their homosexual impulses.

6. Hatterer, L. (1970). *Changing Homosexuality in the Male.* New York, NY: McGraw-Hill Book Co.

Hatterer evaluated 710 homosexual men as admitting psychiatrist for the Payne Whitney Psychiatric Outpatient Clinic of the New York Hospital and in private practice and treated over 200 of them over a 17-year period. Of those patients, he reports that 49 fully recovered from a homosexual orientation, 19 partially recovered, and 76 remained homosexual. Of the recovered patients, 20 married for the first time, and 10 were married and remained married.

7. Mayerson, P., & Lief, H. (1965). Psychotherapy of homosexuals: A follow-up study of 19 cases, In J. Marmor (Ed.), *Sexual Inversion: The Multiple Roots of Homosexuality.* Basic Books Inc., 302–344.

Mayerson and Lief conducted a follow-up study of 19 patients (14 men and 5 women) who had originally presented with "homosexual problems" (p. 331). The mean duration of therapy was 1.7 years, and the mean follow-up was 4.5 years. At the time of follow up, 47 percent of patients were found to be "apparently recovered" or "much improved" and identified themselves as "exclusively heterosexual." Twenty-two percent of them had originally identified themselves as "exclusively homosexual."

8. Ovesey, L. (1969). *Homosexuality and Pseudo Homosexuality.* New York: Science House.

After a follow-up of five or more years, Ovesey reported the case studies of three successfully treated (homosexual) men. "Success" for men who were being treated to change from homosexuality to heterosexuality was not just "potency" with women, but satisfaction in the "total relationship," including marriage (pp. 123–124). Treatment focused on understanding unconscious motives that had compelled the patients to flee from women and to seek contact with men.

9. Siegel, E. V. (1988). *Female Homosexuality: Choice Without Volition*. Psychoanalytic Inquiry Book Series. Hilldale, NJ: Analytic Press.

Siegel treated 12 females who considered themselves exclusively homosexual at the beginning of treatment. At the conclusion of treatment, more than half had become "fully heterosexual."

10. Socarides, C. W. (1978). *Homosexuality: Psychoanalytic Therapy.* New York: Jason Aronson.

Socarides reported that from 1967 to 1977, 20 of 44 patients (45%) whom he treated using "full-scale psychoanalysis" developed full

"heterosexual functioning." This included having "love feelings for their heterosexual partners" (p. 406).

11. Van den Aardweg, G. J. M. (1968). *Homosexuality and Hope: A Psychologist Talks about Treatment and Change*. Ann Arbor, MI: Servant Books.

Van den Aardweg reported treating 101 homosexuals with cognitive approaches. About 60 percent had at least a satisfactory outcome, while one-third of those changed substantially toward a heterosexual adaptation.

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The following are a list of books printed on the subject of SOCE during the APA time period, which are presented without commentary:

1. Davies, B. & Rentzel, L. (1993). *Coming Out of Homosexuality: New Freedom for Men and Women.* Downers Grove, IL: InterVarsity Press.

2. Davison, G. C. (1991). Constructionism and morality in therapy for homosexuality. In Gonsiorek & Weinrich, *Homosexuality: Research Implications for Public Policy*. Newbury Park, CA: Sage Publishing, 137–148.

3. Ellis, A. (1965). *Homosexuality: Its Causes and Cure.* New York: Lyle Stuart.

4. Feldman, M. P. & MacCulloch, M. J. (1971). *Homosexual Behavior: Therapy and Assessment.* Elmsford, New York: Pergamon Press.

5. Kronemeyer, R. (1980). *Overcoming Homosexuality.* New York: Macmillan.

6. Nicolosi, J. (1991). *Reparative Therapy of Male Homosexuality: A New Clinical Approach.* Northvale, NJ: Jason Aronson.

7. Volkan, V. D. (1992). *The Homosexualities and the Therapeutic Process.* Madison, CT: International Universities Press, 251–275.

Appendix B

The following is a short list of studies which deal with SOCE and its efficacy that were published during the period under consideration in the APA study (1960–2006) but were not included in that study. Many of these studies and their commentary were taken from the report entitled "What Research Shows: NARTH's Response to the APA Claims on Homosexuality" by The Scientific Advisory Committee of the National Association for Research and Therapy of Homosexuality (Phelan, Whitehead, & Sutton, 2009).

Method: Psychoanalysis

1. Berger, J. (1994). The psychotherapeutic treatment of male homosexuality. *American Journal of Psychotherapy, 48,* 251–261.

Berger described two cases of reorientation success. One "resulted in the patient marrying and fathering three children and living a heterosexually fulfilling and enjoyable life" (p. 255). The other was a "successful long-term psychodynamic psychotherapy treatment [that] helped relieve the patient of his original presenting symptoms and enabled him to become comfortably and consistently heterosexual" (p. 255).

2. Beukenkamp, C. (1960). Phantom patricide. *Archives of General Psychiatry, 3,* 282–288.

Beukenkamp treated a homosexual man with individual and group psychoanalysis. The treatment resulted in his reorientation to heterosexuality in both behavior and experiences.

3. Bieber, I., & Bieber, T. B. (1979). Male homosexuality. *Canadian Journal of Psychiatry, 24,* 409–419.

Bieber and Bieber reported that since the original study (Bieber I., "A Psychoanalytic Study of Male Homosexuals," Basic Books, 1962), they had seen more than 1,000 homosexual men and that "the data obtained [were] in accord with the (previous) research findings, thus strengthening validity and reliability" (p. 417). The researchers reported that "we have followed patients for as long as 20 years who have remained exclusively heterosexual. Reversal rates now range from 30% to an optimistic 50%."

4. Coates, S. (1962). Homosexuality and the Rorschach test. *British Journal of Medical Psychiatry, 35,* 177–190.

Coates examined 45 cases of homosexual patients who were treated at the Portman Clinic between the years of 1954 and 1960. He found that 7 of 45 cases (16%) were classified as "better" (p. 180), meaning that patients reported no active homosexual behaviors.

5. Jacobi, J. (1969). Case of homosexuality. *Journal of Analytical Psychology, 14,* 48–64.

Jacobi reported treating 60 patients, 10 percent of whom made a satisfying transformation to heterosexuality.

6. Kaye, H. E., Berl, S., Clare, J., Eleston, M. R., Gershwin, B. S., Gershwin, P., Kogan, L. S., Torda, C., & Wilbur, C. B. (1967). Homosexuality in women. *Arch General Psychiatry, 17*(5), 626–634.

Kaye sent a 26-page survey to 150 psychoanalysts who saw homosexual women in their practice and received back 24 completed surveys. 8 of 15 cases that were reported to be in the "homosexual range" (Kinsey scores of 4–6) at the onset of treatment had shifted to a Kinsey score of 0 (exclusively heterosexual). Kaye concluded, "Apparently at least 50% of them can be helped by psychoanalytic treatment" (p. 633).

7. Lamberd, W. G. (1971). Viewpoints: What outcome can be expected in psychotherapy of homosexuals? *Medical Aspects of Human Sexuality, 5*(12), 90–105.

Lamberd reported three case studies, in which after a one-year follow-up, each of the patients could be considered as successfully treated.

8. MacIntosh, H. (1994). Attitudes and experiences of psychoanalysis in analyzing homosexual patients. *Journal of the American Psychoanalytic Association, 42,* 1183–1207.

A survey of 285 anonymous members of the American Psychoanalytic Association conducted by MacIntosh (1994) revealed that of 1,215 homosexual patients analyzed by those members, 23 percent changed from homosexuality to heterosexuality and 84 percent received significant therapeutic benefits.

9. Ovesey, L., Gaylin, W., & Hendin, H. (1963). Psychotherapy of male

homosexuality: Psychodynamic formulation. *Archives of General Psychiatry, 9,* 19–31.

Ovesey, Gaylin, and Hendin reported successfully treating three men who had homosexual inclinations. After being followed for as long as five years, the men reported that they were able to maintain pleasurable heterosexual behavior, which had been the goal of their therapy.

10. Ovesey, L., Gaylin, W., & Hendin, H. Psychotherapy of male homosexuality: Prognosis, selection of patients, technique. *The American Journal of Psychotherapy, Jul. 19:3.*

The authors describe details and special problems in therapeutic technique in their 1963 study, cited previously.

11. Wallace, L. (1969). Psychotherapy of a male homosexual. *Psychoanalytic Review, 56,* 346–364.

Wallace conducted analysis with a homosexual man who subsequently achieved heterosexual adjustment. After a six-year follow-up, the patient's reported successes included strengthened ego functions and deepened insight into both his fear of heterosexuality and his unconscious fantasies about homosexual encounters, as well as the initiation of satisfactory heterosexual activity.

Method: Behavior and Cognitive

1. Cantón-Dutari, A. (1974). Combined intervention for controlling unwanted sexual behavior. *Archives of Sexual Behavior, 3*(4), 367–371.

Cantón-Dutari, A. (1976). Combined intervention for controlling unwanted sexual behavior: An extended follow-up. *Archives of Sexual Behavior, 5*(4), 323–325.

Canton-Dutari, (1974, 1976) reported on 49 homosexual patients who were able to control their sexual arousal in the presence of homosexual stimuli after treatment. 31 were followed up for an average period of 4 years. 19 subjects (61%) remained exclusively heterosexual, and 9 subjects (29%) reported both heterosexual and homosexual intercourse. 3 reported no sexual behavior.

2. Davison, G. C., & Wilson, G. T. (1973). Attitudes of behavior therapists towards homosexuality. *Behavior Therapy, 45*(5), 686–696.

In response to a 35-item questionnaire sent to 149 randomly selected members of the Association for the Advancement of Behavior Therapy and to all 75 members of the British Behavior Therapy Association, 86 (or 38%) responses were received. The mean claim of percentage of success in decreasing homosexual behavior was 60%.

3. Kraft, T. (1967). A case of homosexuality treated by systematic desensitization. *American Journal of Psychotherapy, 21*(4), 815–821.

Kraft, T. (1970). Systematic desensitization in the treatment of homosexuality. *Behavior Research and Therapy, 8,* 319.

Kraft (1967,1970) treated two homosexual men with a combination of systematic desensitization and psychoanalysis and reported a return to heterosexual functioning in both men.

4. MacCulloch, M. J., & Feldman, M. P. (1967). Aversion therapy in management

of 43 homosexuals. *British Medical Journal, 2,* 594–597.

MacCulloch and Feldman used an anticipatory avoidance aversion therapy in the treatment of 45 homosexuals. Thirty-six patients completed treatment and 25 of them were declared significantly improved at 1–2-year follow-ups with the following Kinsey Scale Rating scores (0 = exclusively hetero-sexual and 6 = exclusively homosexual). 14 of 25 patients scored 0, 9 patients scored 1, and 2 patients scored 2.

5. Maletzky, B. M. & George, F. S. (1973). The treatment of homosexuality by assisted covert sensitization. *Journal of Behavior Research and Therapy, 11*(4), 655–657.

Maletzky and George reported on 10 homosexual men who were treated with covert sensitization behavioral therapy. A 90-percent success rate was found at the 12-month follow-up assessment.

6. Mather, N. J. (1966). The treatment of homosexuality by aversion therapy. *Medicine, Science, and the Law, 6*(4), 200–205.

Mather reported that of 36 homosexuals treated with behavioral and aversion techniques, 25 were considered much improved on the Kinsey scale.

7. Pradhan, P. V., Ayyar, K. S., & Bagadia, V. N. (1982). Homosexuality: Treatment by behavior modification. *Indian Journal of Psychiatry, 24,* 80–83.

Pradhan, Ayyar, and Bagadia demonstrated that by utilizing behavioral modification techniques, 8 of 13 homosexual men showed a shift to heterosexual adaptation that was maintained at a six-month and one-year follow-up.

8. Shealy, A. E. (1972). Combining behavior therapy and cognitive therapy in treating homosexuality. *Psychotherapy Theory, Research and Practice, 9,* 221–222.

Shealy treated a male homosexual using a cognitive-behavioral approach. At the end of 15 1-hour sessions, the subject reported that his overt deviant behavior had stopped and homosexual imagery was much less.

9. Van den Aardweg, G. J. M. (1972). A grief theory of homosexuality. *American Journal of Psychotherapy, 26*(1), 52–68.

Van den Aardweg reported that 9 of 20 patients were completely cured through the use of exaggeration therapy. “Cure” meant that they reported no homosexual fantasies or behaviors after treatment.

Method: Group Therapies

1. Birk, L., Miller, E., & Cohler, B. (1970). Group psychotherapy for homosexual men. *Acta Psychiatrica Scandinavica, 218,* 1–33.

After two years of group therapy with male-female co-therapists, 9 of 26 (35%) overt homosexually identified men shifted completely or towards heterosexuality.

2. Hadden, S. B. (1966). Treatment of male homosexuals in groups. *International Journal of Group Psychotherapy, 16*(1), 13–22.

Hadden reported a 38-percent success rate after treating 32 homosexuals in group therapy.

3. Hadden, S. B. (1971). Group therapy for homosexuals. *Medical Aspects of Human Sexuality, 5*(1), 116–127.

Hadden confirmed a 33-percent success rate in treating homosexual patients in group therapy.

4. Miller, P. M., Bradley, J. B., Gross, R. S., & Wood, G. (1968). Review of homosexuality research (1960–1966) and some implications for treatment. *Psychotherapy Theory, Research, and Practice, 5,* 3–6.

Miller, Bradley, Gross, & Wood reported that similar to behavioral therapy, approximately one-third or more of group therapy clients reported a desired shift in sexual orientation.

5. Pittman, F. S., & DeYoung, C. D. (1971). The treatment of homosexuals in heterogeneous groups. *International Journal of Group Psychotherapy, 21,* 62–73.

Pittman and DeYoung reported that 2 of 6 homosexuals treated in group therapy received maximum benefit and achieved their goal of a satisfactory shift toward heterosexuality.

6. Truax, R., & Tourney, G. (1971). Male homosexuals in group therapy: A controlled study. *Diseases of the Nervous System, 32*(10), 707–711.

Truax and Tourney reported that group treatment of 30 patients compared to 20 untreated resulted in increased heterosexual orientation, decreased homosexual pre-occupation, reduced neurotic symptom-atology, improved social relations, and increased insight into the causes and implications of their homosexuality. Changes in sexual behavior included increased heterosexual dating, decreased homosexual experiences, and increased heterosexual intercourse. While heterosexual functioning improved with further therapy, even more improvement was seen in associated neurotic symptomatology.

Method: Meta-Analyses

1. Clippinger, J. A. (1974). Homosexuality can be cured. *Corrective & Social Psychiatry & Journal of Behavior Technology, Methods & Therapy, 20*(2), 15–28.

Clippinger's meta-analysis of the treatment of unwanted homosexuality demonstrated that of 785 homosexuals treated, 307 (40%) either significantly improved in the direction of their desired goal or had made at least some shift toward heterosexuality.

2. Goetze, R. M. (1997). *Homosexuality and the Possibility of Change: A Review of 17 Published Studies*. New Direction Ministries of Canada.

In an analysis of 17 studies, Goetze found that a total of 44 subjects who had been exclusively or predominately homosexual had experienced a shift toward heterosexual adjustment.

3. James, E. C. (1978). *Treatment of Homosexuality: A Reanalysis and Synthesis of Outcome Studies.* Unpublished doctoral dissertation. Provo, UT: Brigham Young University.

In this meta-analysis, E. C. James (1978) concluded that when the results of all research studies before 1978 were combined, approximately 35 percent of the homosexual clients had shifted to heterosexuality, 27 percent had improved, and 37 percent had neither changed nor improved. Based on her findings, the author stated, "Significant

improvement and even complete recovery [from a homosexual orientation] are entirely possible" (p. 183).

4. Jones, S. L., & Yarhouse, M. A. (2000). *Homosexuality: The Use of Scientific Research in the Church's Moral Debate.* Downer's Grove, IL: InterVarsity Press.

Jones and Yarhouse used meta-analysis to review 30 studies conducted between the years 1954 and 1994. Of the 327 total subjects from all the studies, 108 (33%) were reported to have made at least some heterosexual shift.

Method: Pharmacological Interventions

1. Buki, R. A. (1964). A treatment program for homosexuals. *Diseases of the Nervous System 25*(5), 304–307.

Buki conducted a clinical trial using Parnate (tranylcypromine) with 36 male patients between the ages of 19 and 34 who had engaged in homosexual behavior. 13 out of 36 "show[ed] an unexpected good control over homosexual activities and impulsions" (p. 306).

2. Elmore, J. L. (2002). Fluoxetine-associated remission of ego-dystonic male homosexuality. *Sexuality and Disability, 20*(2), 149–151.

Elmore reported on the remission of homosexual behavior in a 53-year-old man who had been engaging in homosexual activity since his youth as a result of treatment with Fluoxetine.

3. Golwyn, D. H., & Sevlie, C. P. (1993). Adventitious change in homosexual treatment of social phobia with phenelzine. *Journal of Clinical Psychiatry, 54*(1), 39–40.

Golwyn and Sevlie reported change in the sexual orientation of a 23-year-old homosexual man who, after taking Nardil (phenelzine) for shyness and anxiety, reported that he no longer had sexual interest in other men. The authors concluded, "Social phobia may be a hidden contributing factor in some instances of homosexual behavior" and that ". . . dopaminergic agents might facilitate male heterosexual activity" (p. 40).

4. Kraft, T. (1967). A case of homosexuality treated by systematic desensitization. *American Journal of Psychotherapy, 21*(4), 815–821.

Kraft reported on the successful reorientation of a homosexual man treated with methohexital sodium (Brevital).

Appendix C

Studies Reviewed in Both Adams-Sturgis Review and Chapter 4 of APA Report

Adam-Sturgis Review	Chapter 4 of APA Report
Uncontrolled group studies	***Uncontrolled group studies***
Fookes (1960)	Fookes (1960)
Freund (1960)	
Feldman & MacCullough (1965)	Feldman & MacCullough (1965)
MacCullough & Feldman (1967)	MacCullough & Feldman (1967)
Bancroft (1969)	Bancroft (1969)
Freeman & Mayer (1975)	Freeman & Mayer (1975)
Controlled group studies	***Controlled group studies***
McConaghy (1969)	McConaghy (1969)
Bancroft (1970)	
Birk, Huddleston, Miller, & Cohler (1971)	Birk, Huddleston, Miller, & Cohler (1971)
McConaghy & Barr (1973)	McConaghy & Barr (1973)
Tanner (1974)	Tanner (1974)
McConaghy (1975)	
Tanner (1975)	Tanner (1975)
Uncontrolled single case studies	***Uncontrolled single case studies***
Thorpe, Schmidt, & Castell (1963)	Thorpe, Schmidt, & Castell (1963)
Levin, Hirsch, Shugar, & Kapche (1968)	Levin, Hirsch, Shugar, & Kapche (1968)
Quinn, Harbison, & McAllister (1970)	Quinn, Harbison, & McAllister (1970)
Gray (1970)	Gray (1970)
Huff (1970)	Huff (1970)
Larson (1970)	Larson (1970)
Marquis (1970)	Marquis (1970)
LoPiccolo (1971)	LoPiccolo (1971)
MacCullough, Birtles, & Feldman (1971)	
Blitch & Haynes (1972)	Blitch & Haynes (1972)
Curtis & Presly (1972)	Curtis & Presly (1972)
Hallam & Rachman (1972)	Hallam & Rachman (1972)
LoPiccolo et al. (1972)	
Controlled single case studies	***Controlled single case studies***
Colson (1972)	Colson (1972)
Hanson & Adesso (1972)	Hanson & Adesso (1972)
Kendrick & MacCullough (1972)	Kendrick & MacCullough (1972)
Barlow & Agras (1973)	
Callahan & Leitenberg (1973)	Callahan & Leitenberg (1973)
Herman, Barlow, & Agras (1974)	
Herman & Prewett (1974)	Herman & Prewett (1974)
Rehm & Rozensky (1974)	Rehm & Rozensky (1974)
Barlow, Agras, Abel, & Blanchard (1975)	
Sanford, Tustin, & Priest (1975)	Sanford, Tustin, & Priest (1975)
Conrad & Wincze (1976)	Conrad & Wincze (1976)
Total: 37	*Total: 29*

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Bancroft, J. (1969). Aversion therapy of homosexuality: A pilot study of 10 cases. *British Journal of Psychiatry, 115*, 1417–1431.

Birk, L. (1974). Group psychotherapy for men who are homosexual. *Journal of Sex & Marital Therapy, 1,* 29–52.

Birk, L., Huddleston, W., Müller, E., Cohler, B. (1971). Avoidance conditioning for homosexuality. *Archives of General Psychiatry*, 314–323.

Curtis, R. H. & Presly, A. S. (1972) The extinction of homosexual behavior by covert sensitization: A case study. *Handbook of Behavior Therapy with Sexual Problems, 2,* 407–410.

Herman, S. H., & Prewett, M. (1974). An experimental analysis of feedback to increase sexual arousal in a case of homo- and heterosexual impotence: A preliminary report. *Journal of Behavior Therapy & Experimental Psychiatry, 5,* 271–274.

James, B. (1962). Case of homosexuality treated by aversion therapy. *British Medical Journal, 1,* 768–770.

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Larson, D. E. (1970). An adaptation of the Feldman and MacCulloch approach to treatment of homosexuality by the application of anticipatory avoidance learning. *Behaviour Research & Therapy, 8,* 209–210.

McConaghy, N. & Barr, R. F. (1973). Classical, avoidance, and backward conditioning treatment of homosexuality. *British Journal of Psychiatry, 122,* 151–162.

Mintz, E. E. (July 1966). Overt male homosexuals in combined group and individual treatment. *Journal of Consulting Psychology, 30,* 193–198.

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Reflections on the Life and Legacy of Joseph Nicolosi, Sr.: An Interview with Linda Nicolosi

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Fresno, California

Linda Nicolosi is the widow of Joseph Nicolosi, Sr., and served faithfully alongside him for 39 years of marriage before his untimely death in 2017. She is currently republishing all four of Dr. Nicolosi's books under her own imprint, Liberal Mind Publishers. The books are available through josephnicolosi.com, where many of her late husband's articles also remain available. In this interview, she shares her recollections of her husband, their involvement in the early years of NARTH (now the Alliance), and her observations about the current state of the mental health field for those providing care for persons with unwanted same-sex attractions.

Keywords: Linda Nicolosi; Joseph Nicolosi; history of NARTH/Alliance; organized psychology

Linda, I want to thank you for consenting to this interview, which I'm sure the journal's readership will find enlightening. I want to start in the beginning. Could you tell us about your personal background (birthplace, childhood family, formative experiences as a youth, etc.)?

I was born in New York and grew up in a Christian family with traditional values. I was educated at a private Christian girls' boarding school started by D. L. Moody, a well-known evangelist, who first opened the boarding school as a girls' seminary. Today, the school has become exactly the opposite—militantly pro-LGBT-agenda and anti-biblical.

During those years at the school in the early '60s, I got to see firsthand how the culture was changing. As a student, I was beginning to experience the pressure of political correctness and to feel constrained

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and angry that common sense views of the world were becoming unfashionable and verboten. I felt a sense of nostalgia, even then, that D. L. Moody's Christian vision was slipping away and that the people around me were simply not noticing or caring what was happening.

There is one incident that stays in my mind. I was a senior, soon to go off to college, and the school had invited Rev. William Sloan Coffin, a very popular minister, to give a speech to us girls. He told us that he believed the Bible didn't forbid unchastity for unmarried people, as long as they loved each other. The other girls swooned—here was this handsome minister encouraging us to do exactly what we wanted to do and giving us biblical justification!

I remember thinking at the time, "Something is wrong with this picture, when adult authority figures are not strengthening our self-control by their teaching and example, but instead are encouraging us to do what we want and to live as we want." That incident planted a seed in my mind that something was radically changing—not just among the younger generation, which is always, of course, a rebellious one—but among the adult authority figures who should be protecting us from our own passions. After all, I had grown up watching *The Mickey Mouse Club* and *Zorro* and *The Beverly Hillbillies* when I came home from school. It was a simple, sweet world where teachers could still get away with rapping your knuckles if you were disrespectful! And it was rapidly becoming something else.

How did you come to meet Joe? How did you come know he was "the one" for you?

We met at a psychology conference in Long Beach, CA, when I was starting out in a master's in psychology, a career which I later decided to abandon. I immediately appreciated Joe's intelligence, humor, inquisitiveness, strong family values, and his iconoclastic nature. He was funny, irreverent and "out there." Yet he had a strong "center" and values that he did not compromise on, especially in terms of his sense of duty towards family.

What are your recollections about how Joe became interested in the psychological care of those with unwanted same-sex attractions? How did you feel about this as his wife?

At first I was not sure about accepting his view of the SSA issue, because I had been educated to see it from a liberal perspective. But even then, I had an uneasiness about what I was learning in school. Something about it didn't match up with reality, and I felt annoyed that I had to spout back the "right" philosophy to get an A from my psychology professors at Cal State Long Beach. I indeed got the A's, but I had to regurgitate their agenda. This was true in Gender Studies and Feminist Studies especially.

Joe got interested in the subject because he had several clients with SSA and he saw how closely they fit the classic family pattern, but because he hadn't been taught about the subject in grad school, he had to learn about it on his own. He became curious about why he hadn't been taught about the rich clinical observations in the psychodynamic literature and he began to suspect a politically motivated "forgetting" within his profession. How right he was!

How did NARTH get started? Many Alliance members know that NARTH was founded in 1992 by Benjamin Kaufman, Charles Socarides, and Joe, but among these three giants of free inquiry, who approached whom? How long did it take to birth the organization?

I believe it was Ben Kaufman who first approached Joe. Ben related how he had acted as a Good Samaritan in giving mouth-to-mouth resuscitation to an accident victim, but then when he wanted to know the man's HIV-status, so he could protect himself if necessary, the hospital refused to tell Ben because of the special privacy protections given to patients in response to lobbying efforts from the gay community. That was yet another incidence of common sense yielding to political correctness. Ben, Charles, and Joe knew they needed to rally the mental-health community to protect their rights to offer treatment, as the gay lobby's power grew and slowly began a professional and cultural stranglehold.

What were the organizations' main challenges during the early years?

Money—NARTH was broke. Joe, myself, and our son Joe Jr. folded and stuffed the NARTH Bulletins on our kitchen table. I wrote the articles. But we had a sense of mission that it had to be done.

You were very involved in NARTH's early years as well. Tell us a bit about your role in supporting Joe and the organization.

I had always wanted to do something of value in my life, something to promote the truth. Just "making a living" would have never satisfied that need. My mother's family had been missionaries and ministers, and I think their spirit came into my spirit and drove me to pursue this work. So, I did virtually all the writing and editing for NARTH.

I also read slews of gay publications and studied the professional literature on homosexuality so I would be educated on what I was doing. It quickly became apparent to me that homosexuality was not just something benign—i.e., a different way of loving—but that it had a very dark side that was quite intrinsic to it. This was also true of lesbianism.

I saw that people caught up in homosexuality started out as innocent and blameless, but that a failure in same-sex attachment later formed their romantic and erotic attractions into something not natural to us as human beings. I am a great lover of nature. How could using the wrong body parts (oral and anal) be anything but a violation of human dignity? How could putting on a dildo and acting like a man with one's woman partner be a true and authentic form of loving? We all have a designed and created nature, and to live our lives most fully, we must confirm ourselves to it, instead of living out and celebrating our brokenness.

Because the world was losing its ability to perceive this truth, I felt driven to write about it and to help Joe in his work. He had a remarkable clinical astuteness, as well as great patience with people and empathy for them. Over and over he would tell me, "I love my work." Sometimes he would cry when he would tell me how some of his clients had been neglected and abused as children.

What are some of your more memorable experiences?

I worked extensively with Robert Spitzer to get the Spitzer study prepared for publication and published. That was considered a landmark study at the time, though Spitzer later became concerned that his interview subjects might not have all been frank with him, and, as he was under strong pressure from the gay community—which greatly disliked the results—Spitzer later asked the journal's editor to withdraw the study. The editor wisely refused to do that. I wrote an analysis of my time working with Spitzer, which was published at *The Bob Spitzer I Knew—Crisis Magazine* (https://www.crisismagazine.com/2016/the-bob-spitzer-i-knew). Spitzer, many people

like to forget, was the same person who was the driving force to remove homosexuality from the diagnostic manual, and also the person who told me, for publication, years afterward, "In homosexuality, something's not working."

Joe would also want me to mention a little "coup" I had while I was studying the professional journals for material for the NARTH Bulletin on homosexuality. I was the source of what *The National Psychologist* called a "public relations nightmare" for the American Psychological Association. Not a bad thing to be able to do!

I had alerted talk-show host Dr. Laura Schlesinger about an article published in an APA journal entitled, "A Meta-analytic Examination of Assumed Properties of Child Sexual Abuse Using College Samples." After I exposed it, the study drew the attention of Congress, which called for an investigation.

The outrage focused on the authors' conclusion, based on their analysis of child-molestation studies, that "the negative effects [of sexual abuse] were neither pervasive nor typically intense." One of the study's authors, Robert Bauserman, was openly associated with the pedophilia movement. As *The National Psychologist* reported, according to the study, sexual relationships between adults and children are not as harmful as once believed, and not all childhood victims of sexual abuse necessarily suffer mental illness as a result. . . . The uproar which followed could be seen in U.S. media and from Berlin to Bangkok. But poor Dr. Laura paid dearly for that uproar. The gay movement turned on her with a vengeance, and before long, her talk-show career was over.

Another thing I learned during my NARTH years was that there is a ripple effect in society when homosexuality goes from being compassionately tolerated—i.e., as an unfortunate situation for which we have sympathy and understanding—to being "celebrated" as a positive good.

As one example: same-sex attraction, particularly in men, threatens friendship—the natural and beautiful bond of camaraderie that should always be free of eroticism and even the suspicion of eroticism. Thus, SSA begins to break down the social order and push society into pansexuality. Any relationship, particularly a healthy, innocent mentorship, can now be suspected of being erotic, because sex now can "legitimately" occur between people of the same gender.

During my years with NARTH, I also came to a greater appreciation of why Jewish tradition has required separation and division—the separation of male from female, good from evil, sacred from profane, life from death. Without those fundamental separations, civilization begins a slow slide into barbarism. We see that today in society's denial of gender differences, and in the sexualization of children who aren't left alone by adults to be children, while adults themselves are acting like kids! I think of Sen. Elizabeth Warren telling a transgender child on TV that "if I get to be president, I'll come and ask for your personal approval before I nominate an education secretary." What happened to respect for the wisdom of adults? Not to mention, of course, that a nine-year-old boy can hardly be trusted to decide that he "is" a girl, and thus set himself on a lifelong course of sterility, surgical mangling of his body, and hormone treatments.

As my aged mother-in-law used to say, "It's a crazy world."

How did Joe's Catholic faith influence his life's work of helping men with unwanted same-sex attractions?

He saw the world as designed, and God—not man—was the designer. He knew we cannot escape our human natures, which are inevitably gendered.

I twice had the pleasure of having lunch with you and Joe at your home in SoCal. One of my main recollections of our time together was how the Joe at home was such a gentle soul, with a particular interest in painting and growing his garden. This was a different Joe than I had typically seen in his sometimes-outspoken public presentations and certainly unrecognizable from the Joe that was being demonized by the gay activists. What can you share about this side of your husband?

Because Joe had many interests that were not typically masculine—he loved art, opera, and cooking—he knew firsthand that a man can be gender-atypical in some ways (that is, esthetically oriented) and still fully embrace his masculine nature. His father gave him that gift, because although his father was tough, he delighted in Joe and would have given his life for him. So Joe had an interesting combination of masculine strength and Alpha-like dominance, but yet another side of feminine tender-heartedness and great affection, especially for children and animals.

I recall Dean Byrd often asking APA folk, "Is there a place for someone like me in the APA?" In this regard, was Joe hopeful or pessimistic about the future of organized psychology? Did he have a belief about where the field of psychology was heading and what was going to happen to clinicians doing this work?

Joe saw that in the short term, things were going to get ugly, and they have. But he believed that reality ultimately comes back to our awareness, and that the truth will reassert itself at some point.

Would the recent explosion in trans activism within psychology and medicine have surprised Joe?

Joe wouldn't have done well with what's happening now, because he had little patience for hiding, mincing words, compromising on the truth, and playing nice with falsity. He would have probably gone on TV and said something, in response to a provocative question, that would have gotten him kicked out of his profession. He was rather Trumpian in his tendency to just say what he thought and let the chips fall where they may. In fact, it was me, throughout his career, always trying to soften his bluntness and the potential for abrasiveness that came with his speaking very forthrightly.

It has now been a few years since Joe's sudden passing, and his loss is still felt by all who knew and cared about him. Could you tell us about your experience being with him during his illness and how you are doing now?

His illness was only for a couple of days, as he died of a virulent strain of the flu. Up to that time he had been going to the gym and working his usual long hours. He died with his boots on, as they say. In some ways that suited his nature as he had little patience with illness or any restriction on his Type-A personality.

I am doing well enough, although a day does not go by that I don't think of my husband. We were together about 40 years.

Although some have distanced themselves from Joe's innovative efforts in providing professional therapeutic care for unwanted same-sex attractions, what do you anticipate will be his ultimate legacy?

I think his main legacy will be that he told the truth about the causes and nature of homosexuality.

What are your current interests and involvements?

I am republishing Joe's books, which were banned by Amazon even though they had been selling very well. A gay activist complained about them, and Amazon caved in and dropped them. I am working on a final book, "The Best of Joe Nicolosi." I'm maintaining Joe's website, josephnicolosi.com.

Is there anything else you would like to say to clinicians and other Alliance members doing work in this arena?

Yes. As I reflect on what's happened to the mental-health profession, I lament the loss of those precious psychoanalytic insights in the now-forgotten clinical literature—the brilliance of the old analysts and their advancement of our understanding of human nature. Unfortunately, a lot of their brilliance is buried under dense technical language and is not accessible to the layman, or even today's clinician. I've tried to wade through it myself and frequently given up in frustration.

I think this shift in the profession all started in the '60s with the mantra, "I'm OK, you're OK." It was the anti-authoritarian demand to be labeled normal just because a person *believed* he was normal. The "I'm OK, you're OK" trend was an outgrowth of the demons inherent in democracy—that ugly leveling effect of the democratic spirit. We now dare any person outside of ourselves to make value judgments of any kind about our chosen identity. "Who is someone else—especially an authority figure—to tell me that my wish to be the opposite sex is not beautiful and good, simply because I say it is?"

As a result, most psychologists have turned the henhouse over to the foxes. The profession has become an empty shell of shallow behavioral studies without attempt at insight. There are endless, grievance-based studies that demand the affirmation of alternative lifestyles. The latest (coming from gay psychologists) is the push for social affirmation of "consensual non-monogamy." They want psychologists to remove the stigma from promiscuity.

Besides debasing social norms and shaming psychologists of traditional values, the profession is giving up on the search to grasp the totality of our human nature. What a loss!

For those who still seek the truth, I'd say, "Keep the flame burning."

The Creation and Inflation of Prevalence Statistics: The Case of "Conversion Therapy"

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In this review, I offer a critical analysis of the Williams Institute's Generations Survey and the National Center for Transgender Equality's United States Transgender Survey. On the basis of these surveys, claims are being forwarded that hundreds of thousands of minors and adults have been exposed to the torturous practices of "conversion therapy" and tens of thousands more are in imminent danger of suffering that fate. However, non-specific single-items in the Generations Study and the U.S. Transgender Survey are being misused to support non-specific restrictions on professional therapy. The methodological limitations of these surveys have likely resulted in the inflation of "conversion therapy" prevalence statistics and a serious distortion in the public's understanding of this topic. These statistics can hardly be considered a scientifically responsible basis for legal prohibitions on client-centered, professional change-allowing and fluidity-exploring talk therapies. The Williams Institute, the National Center for Transgender Equality, and scholars utilizing their data are not living up to claims of ideological independence and scientific rigor.

Keywords: Conversion therapy, prevalence rates, Williams Institute, National Center for Transgender Equality, survey misuse

A pair of surveys are being frequently cited as a basis for legal prohibitions on therapies that allow clients to pursue a self-determined goal to explore their potential for change in unwanted same-sex attractions, behaviors, and gender identities. They are being cited in legal briefs, academic journals, and even presidential campaigns.[2] A survey from the

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[2] See, for example, page 9 of the following white paper from Pete Butigieg's 2020 presidential campaign: https://storage.googleapis.com/resources.peteforamerica.com/documents/LGBTQ_white-paper.pdf

UCLA School of Law–affiliated Williams Institute purports to provide statistics on the prevalence of "conversion therapy" as it pertains to sexual orientation (also referred to as sexual orientation change efforts, or SOCE[3]) (Mallory, Brown, & Conron, 2018, 2019). The second survey, published through the National Center for Transgender Equality, is being touted as providing unambiguous evidence on the occurrence and negative effects of gender identity conversion efforts (GICE) (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Since these surveys are being offered by therapy ban supporters as essential justifications for legal prohibitions on professional and religious speech, it is important that this research be critically scrutinized to determine the extent to which such conclusions may be scientifically defensible. In what follows, I will examine these surveys separately, providing first a summary of the survey findings relative to professional psychotherapy followed by a critical examination of key methodological and interpretive issues with particular reference to recent GICE research. I conclude with a general discussion of the significance of these surveys in terms of the use and abuse of recent scientific research to advance policy agendas.

The Williams Institute's Generations Survey

The Williams Institute describes itself as dedicated to "conducting rigorous, independent research on sexual orientation and gender identity law and public policy." A number of well-known LGB and allied scholars are affiliated with the institute, including M. V. Lee Badgett, Ph.D.; Nanette Gartrell, M.D.; and Ilan H. Meyer, Ph.D., who served as the principal investigator of the survey utilized to derive SOCE prevalence statistics. Although its mission is to provide research to support such policy initiatives as "conversion therapy" bans and the federal Equality Act, the Institute touts a statement of independence and objectivity (Williams Institute, n.d.):

> The Williams Institute is committed to the highest standards of independent inquiry, academic excellence, and rigor. Research findings and conclusions are never altered to accommodate other interests, including those of funders, other organizations, or government bodies and officials.

According to the Institute's Generations Survey findings, 695,000 LGBT adults have undergone conversion therapy, including about 350,000 LGBT adults who were "subjected" to conversion therapy as adolescents (Mallory et al., 2019; cf. http://www.generations-study.com/). Furthermore, the Institute's report predicts that 16,000 youth (ages 13–17) in America will receive conversion therapy from a licensed clinician before age 18 in addition to 37,000 youth who will receive conversion therapy from a religious spiritual advisor before age 18. These are startling numbers and no doubt cited so frequently because they give the impression of an urgent crisis affecting hundreds of thousands of sexual minorities, including tens of thousands of adolescents. Clearly, it is much easier to pass favored legislation and public policy if there is a crisis of the magnitude portrayed in the Institute's report.

[3] Although both surveys use the terminology of conversion therapy, to avoid confusion I will generally refer to SOCE when discussing information relative to professional exploration of sexual attraction and behavior fluidity and GICE when discussing professional exploration of fluidity in gender identity.

Disconcerting Details

Despite the Institute's claims of objectivity and rigor, even a cursory examination of their report appears to bring such claims into question. The first paragraph of the executive summary asserts, "Efforts to change someone's sexual orientation or gender identity are associated with poor mental health, including suicidality" (Mallory et al, 2019, p. 1). These alleged outcomes are supported in footnotes referencing studies by Flentje, Heck, & Cochran (2013), Weiss et al., (2010), Shidlo & Schroeder (2002), Ryan et al., (2020), and the 2015 U. S. Transgender Survey (USTS), the latter of which I examine in detail below. As I and others have discussed previously, the articles cited in the executive summary to support the health risks attributed to SOCE are little more than pilot studies with serious methodological limitations and simply cannot be generalized beyond their samples (Rosik, 2014, 2019). It is difficult to construe such unqualified generalizations as objective or rigorous.

A second example is more egregious yet. The Institute's report provides statistics that suggest large majorities support bans on SOCE with minors provided by health care professionals, citing recent polling in six states. One of these states was North Carolina, where the executive summary reported 80% of people in this state support laws banning conversion therapy on minors. The footnote for this statistic further notes,

> In response to the poll, 80% of respondents immediately said that they think conversion therapy should be illegal on children under 18. Half of the remaining 20% of respondents (those who initially agreed or had no opinion) agreed that the practice should be banned when they had a better understanding of what the practice entails. (Mallory et al., 2019, p. 10)

The footnote also provides a link to the source of this polling, the advocacy group Born Perfect NC. Born Perfect NC's website provides a report on the polling, which includes verbatim the above description included in the Institute's executive summary (Nichols & Polaski, 2019). This all sounds quite bleak for the future of change-allowing therapies with minors if 90% of respondents in a fairly conservative state such as North Carolina are in favor of legal prohibitions. However, as is often the case in these matters, the devil in in the details. Should anyone have enough curiosity to ask, "How does Born Perfect NC define conversion therapy?" that person would discover the following:

> Conversion therapy, also referred to as "reparative therapy," is the practice of attempting to change an individual's sexual orientation or gender identity. Techniques can range from extreme electroshock treatments or institutionalization to "counseling" services based on pseudoscience. (Born Perfect NC, n.d.)

If citing such statistics is an example of the William Institute's objectivity and rigor, then they appear to set a very low bar indeed for these standards. That professional change-allowing therapies do not use electroshock or other aversive and coercive practices is well-known with the LGBT academic community, as was recently acknowledged by the acclaimed LGBT legal advocate and University of Utah College of Law professor Clifford Rosky, who stated to the gay press ("Watered down anti-conversion therapy bill," 2019), "Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades." Thus, when one digs into the facts

of this polling, the real story is not that 90% of North Carolinians support banning conversion therapy for minors. No one I know would support such practices as they are depicted. The real story of an impartial and honest accounting about this polling, one free of advocacy objectives, is that 10% of respondents apparently support institutionalized electroshock treatments of sexual minority minors. In a less politically contaminated environment, scholars such as those affiliated with the Williams Institute would seek out and align with Alliance professionals to jointly counter such public sentiment. However, by uncritically adopting this polling for advocacy purposes, the Williams Institute seems to have engaged in sloppy science at best or, at worst, a conscious effort to manipulate public opinion about change-allowing talk therapies through their use of a prejudicial and deceptive Born Perfect NC survey. Their independent inquiry and research appear to include independence from exposure to alternate critical perspectives that could have identified and constrained such excesses, which are common to groupthink and confirmation bias dynamics.

The description of conversion therapy presented in the text of the Institute's executive summary is a slight improvement over the distortions of the Born Perfect NC depiction. The Institute acknowledges that, "Currently, talk therapy is the most commonly used therapy technique" (Mallory et al., 2019, p. 2). Unfortunately, they go on to quote the APA Task Force report:

> Some practitioners have also used "aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts." (p. 2)

Again, context here is everything, and the Williams Institute fails to provide it. Examining page 22 of the Task Force report, it becomes apparent that the APA is referring to techniques from the 1960s and 1970s. The actual beginning of the above quote from the report omitted by the Institute reads, "*Behavior therapists tried* a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; . . ." (American Psychological Association (APA), 2009, p. 2; emphases added). The Institute makes no effort to clarify that these techniques are no longer in use by licensed therapists as pertains to sexual orientation change, including clinicians who are open to the possibility of sexual attraction and behavior fluidity.

If the Williams Institute's numbers are not in some manner inflated, and even if only 1% of the tens of thousands of minors the Williams Institute alleges have undergone or are undergoing SOCE with a licensed therapist have been subjected to the aversive practices suggested by the executive summary, it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. Strikingly, however, Drescher et al. (2016) noted, "To our knowledge, there have been no formal actions by a regulatory body against a provider for engaging in conversion therapy." I am aware of no such documented regulatory action up to the present day, despite the passage of therapy bans in several states. The most probable means of understanding this disconnect between the Williams Institute's numbers and the lack of any therapist having lost a license for unethical SOCE-related conduct is that licensed practitioners of change-allowing therapies (whatever their number) are

conducting themselves in an ethical and professional manner.

Questionable Deductions and Original Sins

The Williams Institute's process for deriving their prevalence statistics for SOCE and GICE is a sequence of laborious deductions. Funded primarily by a $3.4 million federal grant from the National Institute of Child Health and Human Development, Gallup recruited LGB-identified participants for the Generations Study between March 28, 2016 and March 30, 2017. Gallup screened 366,644 individuals for inclusion in the Generations Study. Of these, 3.5% (n=12,832) identified as LGBT. Eligibility criteria for inclusion in the study as LGB were (1) identification as LGB, queer, or same-gender loving; (2) age 18–59; (3) Black, Latino, or White; (4) 6th grade education or higher; and (5) sufficient English speaker. Of the LGBT-identified persons, 27.5% (n=3529) met the eligibility criteria, 80% (n=2823) of these agreed to participate in the Generations Survey, and 48% (n=1345) of these actually completed the survey.

What jumps out from these statistics and appears to go unexplained is the fact that the final survey respondents represent *just 10.4%* of the originally identified potential LGBT participants. No explanation is given for why 72.5% of the LGBT participants originally identified were deemed ineligible for inclusion in the survey. It is simply not reasonable for such a high level of participant exclusion to have occurred solely on the basis of the inclusion criteria described. Moreover, having nearly half of the eligible participants not finish the survey raises serious questions about the possibility of non-random, systematic differences between completer and non-completers that might affect the results and seriously limit the researchers' ability to generalize their findings. As the APA Report (2009) noted, "Put simply, dropout may undermine the comparability of groups in ways that can bias study outcomes" (p. 29). There is no indication from the executive summary that these important questions were ever discussed and explored to determine how these groups (e.g., original LGBT identified versus survey eligible LGB identified; survey non-completers versus completers) may have differed from one another. These are critical analyses that needed to be done but appear not to have been conducted for unknown reasons.

While these issues of eligibility and dropout rates are highly concerning, there is also the matter of how the Williams Institute arrived at its LGB prevalence statistics for SOCE. The Generations Study data found 6.7% of LGB adults ages 15–59 reported having received treatment to change their sexual orientation. This proportion was then multiplied by the proportion of adults (5.3%) ages 18–59 who identified as LGBT in the 2015–2017 Gallup daily tracking survey. This number was then multiplied by the proportion of cisgender LGBT individuals (87.7%) ages 18–59 as determined by the 2014–2015 Behavioral Risk Factor Surveillance System survey conducted by the Centers for Disease Control. Finally, this proportion was applied to the number of adults ages 18–59 according to 2016 population estimates from the 2010 U.S. Census. In addition, 49.9% of LGB adults in the Generations Survey reported having received SOCE as minors. Some estimates suggest the 5.3% prevalence number for LGBT adults may be a high figure (cf. a 4.5% figure reported by Newport, 2018). However, there is a much larger concern.

A close examination of the item utilized to identify SOCE participation in the survey raises concern that vague and limited item language may be the "original sin" in the William Institute's prevalence statistics.

Specifically, item 133 states, "*Did you ever receive treatment from someone who tried to change your sexual orientation (such as try to make you straight/heterosexual)?*" Respondents are then given three options: (1) "*No*"; (2) "*Yes, from a healthcare professional (such as a psychologist or counselor who was not religious-focused)*"; or (3) "*Yes, from a religious leader (such as a pastor, religious counselor, priest)*." Either "*Yes*" response led to follow-up question #134, "*About how old were you the last time you received treatment to change your sexual orientation?*" Not only is the retrospective self-report nature of the survey problematic given the likely need for participants to recall events from decades earlier, but "treatment," "tried to change," and "try to make" are left undefined and are so nebulous one can gain no idea about the frequency or seriousness of the interventions participants have in mind. Does the respondent have in mind electroshock treatment? Generic prayers for healing? A counselor's expressed caution about the respondent pursuing sexual activity as an adolescent? A felt sense the therapist preferred heterosexuality or was a Christian? What are the specific prevalence rates for such wildly divergent "treatments" in the Generations Study? The Williams Institute has no way of knowing.

It is impossible in a single item to obtain information about a complex issue of sufficient detail to know precisely what treatments are being envisioned and responsibly advocate for legal prohibitions. Without identification of the specific treatments experienced by respondents, the linkage of the prevalence statistics to the summary report's definition of SOCE is highly tenuous. Moreover, the single item cannot provide information on whether and to what degree respondents experienced harm or benefit from their treatment, and prior research suggests that some individuals do report positive aspects to their professional SOCE experience (Dehlin et al., 2015).

To obtain prevalence statistics for the adult transgender population who have received "conversion therapy" (in the form of gender identity change efforts or GICE), the Williams Institute started with the proportion of trans adults (13%) who reported GICE from professionals in the USTS (again, more about this survey shortly), multiplied this by the proportion of adults 18 and older who are estimated to be transgender (.6%), and this was applied to the number of adults ages 18–59 in the U.S. Census. The prevalence rate for GICE among trans youth was derived by multiplying the proportion of transgender adults who reported professional attempts to make them identify only with their birth sex or stop them from being transgender (9%) by the proportion for whom this had happened at or before age 18 (51%) according to the U.S. Transgender Survey (USTS) findings. This proportion (4.6%) of respondents who received GICE before age 18 was multiplied by the proportion of youths ages 13–17 who are estimated to be transgender (.73%) and then applied to the number of youth ages 13–17 in the U.S.

It is beyond the scope of this article to deeply examine the adult transgender prevalence rates, but it is worth observing that the .6% figure is a large jump from the prevalence rates for adult natal males (.005% to .014%) and adult natal females (.002% to .003%) provided in the Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (American Psychiatric Association, 2013, p. 454). The .6% transgender population size estimate was also higher than the .39% estimated by Meerwijk and Sevelius (2017) in their meta-regression of 12 population-based probability samples. Such rapid increases in transgender prevalence are underscored by the thirty-fold increase (from 77 in 2008 to 2590 in 2018) of children being treated for gender dysphoria at London's

Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (Donnelly, 2019). Contrary to claims by Meerwijk and Sevelius (2017), who speculate that such increases are solely the result of people feeling freer to report that they are or identify as transgender, such rapid increases are difficult to explain as simply a reduction in stigma leading to more openness to treatment and are likely to suggest some element of social contagion (Zucker, 2019).

2015 U.S. Transgender Survey

The other survey gaining rapid traction in political and academic circles is the 2015 U.S. Transgender Survey (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Data from this survey was not only used by the Williams Institute in deriving their GICE prevalence statistics but is currently being utilized to assert harms from change-allowing talk therapies are widespread and sufficient for professional and religious engagement in such efforts to be deemed a serious health hazard (Turban, King, Reimer, & Keuroghlian, 2019). The USTS is described as a cross-sectional survey conducted by the National Center for Transgender Equality (NCTE) between August 19 and September 21, 2015. It is the largest existing survey of transgender adults, comprised of 27,715 transgender adults living in all regions of the United States. Overall, 13.5% of the sample reported that one or more professionals, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender. Mental health distress was significant for this population. For example, 40% of survey respondents reported having attempted suicide in their lifetime, compared to 4.6% of the general population. The report included a section entitled, "Conversion therapy and other pressures to de-transition," which noted in addition to GICE prevalence that

> participants who had a professional try to stop them from being transgender were . . . far more likely to currently be experiencing serious psychological distress (47%) than those who did not have the experience (34%) . . . more likely to have attempted suicide (58%) than those who did not have the experience (39%) . . . nearly three times as likely to have run away from home (22%) than those who did not have the experience (8%) . . . more likely to have ever experienced homelessness (46%) than those who did not have the experience (29%) . . . more likely to have ever done sex work (18%) than those who did not have the experience (11%). (James et al., 2016, p. 110)

Attempts to link GICE and such psychological distress are now unsurprisingly appearing in professional journals (e.g., Turban, Beckwith, Reisner, & Keuroghlian, 2020). Following an in-depth examination of the survey with particular reference to its limitations, I will attend to concerns with how it is being promoted in the scientific literature.

Examining Methods and Limitations

Cross Sectional Design

An obvious limitation of the USTS is its cross sectional nature, meaning data are collected from respondents only once at only one point in time. Consequently, cross sectional studies rely on differences that exist in the sample rather than differences that follow intervention and select groups for comparison based on differences rather than random sampling. This contrasts with longitudinal datasets, where respondents are administered a survey on repeated occasions

over an extended period of time. Longitudinal data are necessary for making any definitive statements regarding cause and effect. Hence, from the outset, the survey findings cannot responsibly make the case for GICE *causing* psychological distress. There are many other reasons for avoiding such conclusions, yet none of these reasons seems sufficient for advocates to critically reflect on causal assertions and ethical condemnations (e.g., Turban et al., 2019).

Community-Based Sampling

The survey was distributed through community-based outreach to transgender adults in the United States, with representation from all 50 states. Over 300 transgender, LGBT, and allied organizations promoted and distributed the survey to their members. According to Appendix C ("Detailed Methodology") of the Report, the sample was ". . . created using direct outreach, modified venue-based sampling, and 'snowball' sampling" (p. 295). This leads to an important acknowledgment:

> As a non-probability sample, generalization is limited, meaning it is unclear whether the findings present in this report would hold true for the transgender population of the U.S. as a whole. (p. 295)

Meltzoff (1998), writing in an APA publication, further describes the concerns with this recruitment strategy:

> [Some studies] . . . begin with a few people and ask them to refer friends and acquaintances. Participants who are recruited in this way are asked to refer others. Networks of people . . . are used to generate a sample of the desired size. Such samples can suffer from the narrowness of inbreeding—the sample might be more homogeneous than one would like. The sample is also vulnerable to contamination of the results as a consequence of participants talking with each other about the research experiences. (p. 53)

Although this survey did employ a multitude of people in their outreach and snowball procedures, this likely does not mitigate Meltzoff's concerns but rather implies that the limitations of such an approach to sampling have been committed repeatedly. One probable example of the "narrowness of inbreeding" concerns the exclusion of formerly transgender persons who no longer identified as transgender and may no longer inhabit LGBT venues, which quite conceivably distorts the survey's statistics and conclusions, for example, on the prevalence and rationales of those who de-transition.

The survey sample is thus seriously limited by its reliance on respondents who identified as transgender, rather than all persons with a history of gender dysphoria. The number of individuals who have suffered gender dysphoria at one time but no longer do so is much greater than those who experience persistent and consistent gender dysphoria and come to identify as transgender. Most children (upwards of 85%) with gender dysphoria will eventually identify with their biological sex if allowed to develop naturally (Ristori & Steensma, 2016; Wallien & Cohen-Kettenis, 2008). Furthermore, as noted astutely by Cantor (2019):

> . . . in the context of GD [gender dysphoric] children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender *regardless* of any attempt to change them. (pp. 2–3; emphasis added)

These developmental realities make it very probable the survey failed to capture individuals who felt gender dysphoric but subsequently adopted a gender identity consistent with their natal sex, which further brings into question the surveys statistics on de-transition rates. Nor would such a sample capture people whose gender dysphoria had been alleviated or improved through standard talk therapies that did not foreclose on the possibility of change and fluidity in gender identity.

The Report does acknowledge the possibility of demographic bias in the survey sample:

> Based on the existing research about the transgender population, there is not adequate information available to attempt to correct for bias in the sample based on age, educational attainment, or income. However, there is sufficient evidence to indicate that the race and ethnicity of the USTS sample does not reflect the racial and ethnic makeup of the U.S. transgender population as a whole. (p. 295)

The researchers do apply a statistical procedure referred to as "weighting" in an attempt to make the racial and ethnic demographics of the sample more representative of what is known regarding transgender individuals in the U.S. as a population. However, this attempt is problematic from its conception. Regnerus (2019) has cogently observed,

> . . . the notion of weighting such data makes little sense, since you cannot "generalize" an opt-in sample no matter what you do to it. The [*JAMA Psychiatry*] study treats the survey in the way its designers appear to desire—as if it were a population-based, representative sample of transgender Americans. But it isn't.

If fact, Appendix A of the report (p. 247) indicates 84% of the sample has at least some college education, a level of educational attainment that seems unlikely to be representative. Regnerus compared the sample demographics with demographic characteristics of transgender adults derived from the CDC's 2017 Behavioral Risk Factor Surveillance System (BRFSS), which provides a truly population-based sample. The comparative data he discovered suggests just how unrepresentative the USTS may actually be.

1. Unemployment: 15% in the USTS vs. 8% in the BRFSS.
2. Sexual orientation: 47% of male-to-female identify as LGB in the USTS vs. 15% in the BRFSS; 24% of female-to-male identify as LGB in the USTS vs. 10% in the BRFSS.
3. Currently married: 18% in the USTS vs. 50% in the BRFSS.
4. Child in the household under 18: 14% in the USTS vs. 32% in the BRFSS.
5. General health rated as fair or poor: 22% in the USTS vs. 26% in the BRFSS.

Such noteworthy differences should give objective researchers second and third thoughts about cavalierly generalizing survey findings for the purposes of justifying public policy (particularly those that impinge on free speech rights), but such warnings appear to be going largely unheeded in academic, legislative, and judicial arenas (more on this later).

Definition of Transgender

Despite the Report referring to the USTS as the largest survey of transgender adults, it is apparent that the sample may not be as homogeneous with regard to transgenderism as it is touted to be, with yet further ramifications for generalizability. Again from Appendix A one finds that 12% (n=3,270) of the sample respondents do not think of themselves as transgender. A full 48% (n=13,353) of respondents identify as more than one gender or as no gender and 40% (n=11,353) do not currently live full-time in a gender that is different from the gender associated with their biological sex. When this 40% was asked if they planned to live full-time in a gender that is different from the one associated with their biological sex, 7% (n=770) of respondents answered "no" and another 35% (n=3,862) responded they were "not sure." Nine percent (n=2,490) of the sample identified as being cross-dressers and 36% (n=9,769) considered themselves to be "non-binary people" as opposed to transgender men and women. Finally, 14% (n=3,946) of respondents were somewhat to very uncomfortable with being described as transgender.

These numbers raise serious questions about how transgender this transgender survey really is. They suggest that the term transgender in this context is functioning as an umbrella term inclusive of cross-dressers, the non-binary, and even respondents who do not really want to be identified as transgender. No statistical comparisons appear to have been conducted to discern the similarity or dissimilarity of these subgroups. Hence, it is difficult to determine the appropriateness of generalizing from totals obtained by summing across these respondent subgroups to the transgender population as a whole. To do so without such knowledge is a dubious practice at best.

Retrospective Recall

The USTS Report provides statistics indicating the age respondents were when they experienced GICE: "More than three-quarters (78%) of respondents were under the age of 25 when they had this experience, 51% were 18 or younger, and 28% were 15 or younger" (p. 109). While information on age of respondents was not presented in the Report, Turban, Beckwith, et al. (2020) reported the mean age of survey participants was 31.2 years. Using this average as a rough estimate of those who recalled their experience of professional GICE, it appears these respondents are likely recalling events that occurred 6 to 16 years earlier, and in some instances a much lengthier time delay than that. The issue of retrospective recall is problematic and should be noted in all communications about these statistics. As observed by the APA (2009) Task Force, "People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall" (p. 29).

Lack of Specific Details of GICE

In a manner similar to the Generations Study, the USTS utilizes a single item to identify experiences of GICE (p. 109): "*Did any professional (such as a psychologist, counselor, religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?*" Subsequent questions inquire about the age of respondents when experiencing GICE and whether the provider was a religious or spiritual counselor/advisor. Similar to the Generations Study item on SOCE, the USTS item on GICE employs non-specific language ("*make you identify*," "*try to stop you*") regarding practices that makes it is impossible to determine what sort of experience or intervention respondents may

have had in mind. It is highly plausible that respondents included in this vague language professionals who adopted the "watchful waiting" approach to care, the worldwide professional standard wherein transitioning is not encouraged for children and adolescents under the age of 16, in order to allow natural developmental changes and fluidity in gender identity to occur, possibly resulting in the remission of dysphoria and avoiding irreversible medical interventions (Cantor, 2019; de Vries & Cohen-Kettnis, 2012; Zucker, 2019; Zucker et al., 2012). Respondents might also interpret as GICE insistence by the clinician that they address serious co-occurring psychological disorders before pursuing transition, which are common in this population (Heylens et al., 2014; Kaltiala-Heino et al., 2015; Zucker, 2016). Likewise, a detailed discussion of the significant risks associated with hormonal and surgical intervention could be perceived by respondents as an attempt by the therapist to dissuade them from transitioning.

Regnerus (2019) again states these concerns cogently:

> Given the hundreds of questions and items the United States Transgender Survey, or USTS, posed to its respondents, that it lumps any scenario that does not involve unqualified affirmation (including "watchful waiting" for minors) into one imprecise, binary measure is, I hold, psychometrically irresponsible . . . in the USTS survey lingo, an ethical discussion of risk could be interpreted by the patient as "trying to stop you being trans." In other words, obtaining informed consent may constitute GICE.

Knowing nothing about the precise clinical context, therapeutic modalities, or specific interventions involved in respondents' perceptions of GICE makes it likely the prevalence statistics are inflated by the inclusion of responsible, ethical practice alongside potentially ill-advised and/or ethical dubious interventions (e.g., enforcing rigid gender role attire and behavior). The situation is thus one in which an ambiguously defined survey item is being utilized as justification for similarly imprecise legal bans of change-allowing professional care for gender dysphoric individuals. This is simply irresponsible advocacy and activism that has done away with necessary scientific circumspection.

Policy Priorities of Transgender People

One final aspect of the USTS data is important to discuss in light of efforts to legally prohibit change-allowing therapies. As part of the survey, respondents were asked about their priorities for public policy. Although 90% of participants indicated that "conversion therapy" was an important priority to them (but placing it only 14th out of the 17 issue options), only 1% identified it as their top policy priority. The leading policy priority among respondents was addressing violence against transgender people, which received the top ranking among 25% of the sample. Obtaining insurance coverage for transgender-related health care came in second among respondents' top policy priorities with 15% support. Addressing racism came in third with 11% endorsement.

What these statistics suggest is that for all the bad publicity surrounding GICE, transgender people are actually much more concerned about their physical safety and access to health insurance. If these numbers are to be believed, it would seem that most respondents do not perceive GICE to be physically harmful (contra the common linking of GICE and SOCE with outdated aversive practices such as electro shock therapy), at least in terms of making it a

policy priority. One is left to wonder whether the push to ban whatever is construed to be GICE is more reflective of the priorities of activists than those of the actual transgender community. Consequently, it is an open question as to whether the transgender community's safety and well-being would be better served by shifting all the time, money, and energy currently being spent to promote therapy bans into supporting public policy efforts and legislation to protect them from physical violence. Such efforts would rightly have received bipartisan support and promoted cooperative action among interest groups that are now divided over therapy bans.

In spite of all the aforementioned concerns, which are by no means exhaustive, the uncritical use of the USTS data on GICE has begun to show up in the academic literature. I turn to two examples of this practice now.

Recent Research Employing the USTS Data on GICE

Recently, and in conjunction with the growing social profile of transgender issues, the USTS findings are being used to document the alleged harms from GICE, providing an empirical basis for legal prohibitions. At the forefront of these efforts is Jack L. Turban, M.D., currently a resident physician in psychiatry, at the Massachusetts General Hospital, Division of Child and Adolescent Psychiatry. He led two research teams publishing articles on this topic that can serve as exemplars of what is concerning about this use of the USTS data relevant to GICE (Turban, Beckwith et al., 2020; Turban, King et al., 2019).

Turban, King et al. (2019)

In this study, the researchers examined "psychological attempts to change a person's gender identity from transgender to cisgender (PACGI)" (p. 1452—it is admittedly difficult to keep up with the explosion of acronyms in this literature; I will continue to use GICE here for the reader's ease of comprehension). Using USTS data, the authors note that GICE has occurred in every state in the U.S. and conclude, "Despite major medical organizations identifying PACGI as ineffective and unethical, 13.5% of transgender people in the United States reported lifetime exposure to this practice" (p. 1452).

Since this study is essentially intended to create a reference for the USTS GICE prevalence statistics in the scholarly literature, I have previously noted most of the problems in such an effort in my examination of the survey. GICE prevalence in the USTS is likely to be inflated due in part to methodological constraints, the most important being the use of an under defined and therefore likely over inclusive single item to refer to GICE. To their credit, the authors acknowledge the problems with self-report and the fact they really do not know critical details about what constitutes GICE for survey respondents.

> Given that participants self-reported exposure to PACGI, however, there is potential for recall bias, particularly regarding the age at which PACGI were experienced. We also lack data regarding specific characteristics of respondents' experiences with PACGI (e.g., modalities used, frequency, duration, forcefulness). Study generalizability is limited because of the use of a non-probability sample. (p. 1454)

They additionally and accurately comment, "The estimates from this study must be interpreted with caution . . ." (p. 1454). Yet it is unclear how much caution they intend to

exercise. Their restraint is brought into question especially in light of their conclusion that the frequency of GICE "warrants public health attention" (p. 1454) given associations with adverse mental health outcomes. So, despite likely inflated prevalence statistics and without knowing any details about what occurred in respondents' experience of GICE, the authors believe this is sufficient empirical justification for banning whatever might be being construed to be professional GICE. As Pruden (2019) has observed, "Of course we should all be interested in eliminating specific abusive practices where they exist, but the solutions currently being considered are the equivalent of solving the problem of drunk driving by outlawing automobiles." Although Turban, King et al. do not provide a basis for adverse mental health outcomes among transgender persons exposed to GICE, they allude to other research they published (Turban, Beckwith, Reisner, & Keuroghlian, 2018), which appears to be an earlier version of their 2020 study. This study is far from impervious to serious critique, as I will detail below.

Turban, Beckwith et al. (2020)

For this analysis, Turban and colleagues examined USTS data to identify recalled lifetime exposure to professional GICE, finding 19.6% of respondents reported such experience. Furthermore, they report any lifetime exposure to GICE as well as lifetime exposure to GICE before age 10 were associated with severe psychological distress during the previous month compared to non-GICE therapy, particularly higher odds of lifetime suicide attempts. They conclude with the recommendation that, "Results from this study support past positions taken by leading professional organizations that GICE should be avoided with children and adults." This conclusion seems rather muted when compared to Turban's statements in mainstream media (Gander, 2019): "We hope that this research will help state legislators understand the magnitude of this problem and the need to pass bans on gender identity conversion efforts."

What state legislators (and others who will be offered these statistics as justification for change-allowing therapy bans) are unlikely to understand is the magnitude of the overreach in Turban's desired aims given the significant limitations of his usage and interpretation of the USTS data. In addition to the limitations of the USTS as previously mentioned, Turban, Beckwith et al. (2020) commit additional and highly disconcerting methodological and interpretive maneuvers, the most noteworthy of which are described below.

Causal Directionality Is Assumed

Because the USTS data are cross-sectional, they cannot determine whether professional GICE caused the mental health distress or whether distressed transgender individuals sought out therapy. Turban and colleagues interpret their findings through the lens of minority stress theory, whose advocates typically presume a causal pathway from experiences of stigma and prejudice (in this instance GICE-related) to adverse health outcomes as the only putative explanation worthy of mention. In conclusions imbued with causal assumptions, the researchers assert, ". . . elevated stigma-related stress from exposure to GICE *may increase* general emotion dysregulation, interpersonal dysfunction, and maladaptive cognitions" and ". . . exposure to GICE *may have been so damaging* that they were impaired in educational, professional, and economic advancement" (pp. e6–7; emphasis added). Seemingly unaware of having already committed such interpretive overreach, Turban, Beckwith et al. (2020) add, "The cross-sectional nature of this study

limits further interpretation" (e7). In point of fact, however, the study design should limit *all* of their interpretations, including a subsequent statement that ". . . rejection of gender identity may have more profound consequences at earlier stages of development" (p. e7). In their strict adherence to the minority stress model, they seem to have missed another (equally—if not more—valid) explanation; namely, trans-gender persons with greater pre-existing psychological distress and emotional disturbance may have been more likely to present for therapy in general and be more interested in pursuing congruence between their biological sex and their gender (GICE?) in particular or may be more likely to be brought to such therapy by their parents.

In this regard, Regerus (2019) expresses similar concerns:

> [T]he authors seem largely uninterested in putting their implied causation—that past conversion attempts affect present mood and suicidality—to the test. Instead, a subtext of injustices committed against the respondents infuses the study, suggesting a decidedly external locus of control in the lives of transgender Americans. This narrative is only interrupted once, when to their credit the authors admit that it "is possible that those with worse mental health or internalized transphobia may have been more likely to seek out conversion therapy rather than non-GICE therapy, suggesting that conversion efforts themselves were not causative of these poor mental health outcomes." I think the average reader would believe this is probable, not just possible.

In addition, individuals pursuing therapy might also tend to be more highly rejection sensitive and at risk for perceiving even ethically conducted therapy to be GICE when, for example, the therapist is not prepared to proceed with facilitating gender transition at the client's desired level of haste.

Absence of a No-Therapy Comparison Group

Turban, Beckwith et al. (2020) compared respondents reportedly exposed to professional GICE with a group exposed to no-GICE therapy. Unfortunately, they determined, "Participants were excluded from analyses if they did not report ever discussing their gender identity with a professional" (p. e4). This exclusion limited comparisons and may have obscured important context regarding the extent of disturbance within the sample. Had the researchers included a comparison group of respondents who reported no exposure to therapy, it would have provided insight into the comparison they did make between respondents reporting GICE versus no-GICE therapy. For example, it would be very helpful to know what the prevalence of lifetime suicidal attempts were among respondents who had no therapy, and to compare this with the prevalence in both GICE and no-GICE participants (as well as general population rates). Were the prevalence of lifetime suicide attempts substantially lower among no-therapy respondents, this might indicate that rates among those exposed to any therapy (GICE or non-GICE) are closer to one another, supporting the distressed-seek-therapy hypothesis and thus placing their difference in important context. Alternatively, if the prevalence rate of lifetime suicide attempts among the no-therapy respondents was in fact quite elevated and close to or equivalent to the no-GICE respondents, this could also suggest that reported GICE exposure provided little explanatory information on

why respondents across the sample attempted suicide. Without such context, the comparisons concerning mental health outcomes between GICE and no-GICE therapy experiences have to be interpreted with much more circumspection than Turban and colleagues have displayed.

No Accounting for Adverse Childhood Events (ACEs)

Although the USTS data provide a picture of the transgender population as suffering from serious childhood trauma (see also Baams, 2018; Giovanardi et al., 2018; Schneeberger et al., 2014), Turban, Beckwith et al. (2020) made no attempt to control for this background variable that plausibly might account for a large portion of the mental health outcome discrepancies between GICE and no-GICE therapy exposure. For example, the USTS Report noted:

> The majority of respondents who were out or perceived as transgender while in school (K–12) experienced some form of mistreatment, including being verbally harassed (54%), physically attacked (24%), and sexually assaulted (13%) because they were transgender. Further, 17% experienced such sever mistreatment that they left a school as a result. (p. 4)

The researchers report conducting bivariate analyses to identify and account for potential confounders in their subsequent regressions, but they do not indicate what, if any, possible confounding variables were discovered. However, it is clear that ACEs were inexplicably not a part of this attempt to identify potential existing and preexisting life experiences likely to be influential on mental health outcomes among transgender persons. Consider this quote from a respondent highlighted in the USTS:

> When I was 18, I had to leave where I grew up after threats of physical violence and conversion therapy from my family. My parents were abusive before they knew I was trans, but when they found out, they used that to hurt and control me more. (p. 110)

It is unfortunate that Turban and colleagues do not exhibit curiosity about the impact of childhood trauma with reference to alleged effects of GICE on mental health outcomes both before and after transgender identification. Regnerus (2019) makes a similar observation, commenting, "This lack of intellectual curiosity is unfortunate, the hallmark of an utterly politicized science whose bar for publishing studies on a topic now exploding in popularity is much too low." Again, such omissions in the researchers' analyses create a lack of critical context for interpretive accuracy and make definitive statements about alleged GICE harms quite questionable from a scientific standpoint.

Effects of Accounting for SOCE Exposure

The USTS also included a single question assessing exposure to SOCE, almost verbatim to the question on GICE (substituting the former acronym for the latter) and encumbered by the same severe non-specificity and hence interpretability concerns. For some reason not detailed by Turban and colleagues, these researchers decided to see what would happen to their GICE analyses when they controlled for exposure to SOCE. What they discovered was after this adjustment, all of their outcome measures expect lifetime suicide attempts were no longer associated with lifetime and childhood exposure to GICE therapy compared to no-GICE therapy. The outcome variables that washed out when controlling for SOCE exposure included suicidal

ideation (lifetime and in past 12 months), suicidal attempt in the past 12 months, suicide attempt requiring inpatient hospitalization in the past 12 months (for lifetime GICE exposure), severe psychological distress in the past 12 months, and lifetime cigarette and illicit drug use (for GICE exposure before age 10). Turban, Beckwith et al. (2020) do not really interpret these findings, and there is little if any literature to indicate that SOCE exposure is widely reported by transgender persons or GICE is frequently encountered by LGB individuals. It is conceivable that reports of exposure to GICE and SOCE may function primarily as proxies for severe and overlapping pre-existing psychological distress among these groups that is not attributable to therapy experiences. Consequently, accounting for distress associated with SOCE would largely account for the distress and outcomes associated with the GICE.

Turban and colleagues address the SOCE comparison only once in their discussion section:

> Based on the findings of the current study, it appears that transgender people are exposed to GICE at high rates, perhaps even higher than the percentage of cisgender non-heterosexual individuals who are exposed to sexual orientation conversion efforts, *although direct comparisons are not possible*. One potential explanation for this is that compared with persons in the sexual minority group, many persons in the gender minority group must interact with clinical professionals to be medically and surgically affirmed in their identities. This higher prevalence of interactions with clinical professionals among people in the gender minority group may lead to greater risk of experiencing conversion efforts. (p. e6; emphasis added)

Why these authors would acknowledge the data do not allow direct comparisons between GICE and SOCE prevalence but then offer *exactly* such comparisons before and after their caution is difficult to fathom. What appears to be more appropriately concluded from this paragraph is that the authors are intent on concluding the rate of GICE exposure among transgender people is greater than the rate of SOCE exposure among sexual minorities and offering favored speculation as to why this might be. The presence of these sorts of interpretive contradictions in this article does not speak well for *JAMA Psychiatry*'s peer review process.

Probable Conflation of Licensed Therapists with Religious Counselors

Turban, Beckwith and colleagues (2020) report, "There were no statistical differences in outcomes between those who were exposed to GICE enacted by religious advisors and those who were exposed to GICE enacted by secular professionals" (p. e6). This conclusion appears to be based on question 13.4 of the USTS, which asks respondents who reported exposure to GICE if the person who provided the care was a "religious or spiritual counselor/advisor." The problem with this line of questioning, of which Turban and colleagues seem unaware, is that many consumers of what is described as SOCE and GICE as well as their families are highly religious and are likely to have sought out both mental health care and spiritual counsel. The USTS questions do not account for this likelihood, and hence the forced binary provider option almost assuredly obscures potential discrepancies between licensed mental health clinicians and unregulated and untrained religious caregivers.

Fiduciary Conflict of Interest

A final point worth noting is that Turban, Beckwith et al. (2020) conclude their ". . . results support the policy positions of the American Academy of Child and Adolescent Psychiatry, . . . which state that gender identity conversion therapy should not be conducted for transgender patients at any age" (p. e8). Footnoted information about the article includes the acknowledgment that the study was partially funded by a Pilot Research Award to the principal author from the American Academy of Child and Adolescent Psychiatry (AACAP). Additionally, the data from the USTS were made available by the National Center for Transgender Equality (NCTE), whose advocacy against GICE is clear. An accompanying disclaimer disavows the funding organizations had any direct role in the study, but advice by Ferguson (2015) suggests problems with influence remain:

> I strongly suggest that psychological researchers should avoid accepting funding from advocacy groups advancing particular policy or social advocacy agendas, however well-meaning these may be. It is probably impossible to avoid any pressure to produce certain results whatever funding source may be available, even with government funding, but avoiding obviously biased sources would be helpful. (p. 533)

Any reasonable person will naturally assume Turban and colleagues understood implicitly that swift and draconian consequences would have followed for reporting and/or interpreting findings in a manner inconsistent with the AACAP GICE policy position or NCTE advocacy interests. These consequences would no doubt include professional ostracization and future inaccessibility to all funding streams and databases provided by organizations with vested policy interests in opposition to GICE. These are high stakes indeed for the authors, which surely would have intruded upon whatever scientific objectivity and circumspection they believed they were bringing to the subject matter. Disclaimers aside, the conclusions of this study were likely to have been known to the authors and tacitly expected by the funders before the first statistical analyses on the data were even conducted.

Summary and Conclusion

What can be inferred from the Generations Study, the USTS, as well as the LGBT literature in general is the overwhelming burden of trauma and adversity experienced by this population. People of good will on both sides of the debate over SOCE and GICE should experience deep compassion for the suffering experienced by so many sexual minorities. Compassion, however, cannot replace sober scientific analysis when research is purported to support if not compel legislation and public policy that impinges on unspecified aspects of professional practice and curtails the free speech rights of licensed mental health providers and ethical religious counselors. In this regard, the prevalence statistics and research derived from these surveys concerning exposure to SOCE and GICE must be viewed with great skepticism.

In the years ahead, politicians, judges, professional organizations, and the general public are going to be bombarded with claims that hundreds of thousands of minors and adults have been exposed to the torturous practices of SOCE and GICE, and tens of thousands more are in imminent danger of suffering that fate. Outlier occurrences of unethical or abusive practices in change-allowing professional talk therapies may happen on rare occasion, as is the case among

providers in all therapeutic endeavors, and these should be taken seriously and addressed by the appropriate regulatory bodies. However, these surveys have been utilized to create SOCE and GICE prevalence numbers that are undoubtedly inflated and distort the realities of this professional care, likely in an attempt to achieve favored political and social policy ambitions.

First and foremost, this inflation has occurred by the use of vague and over-inclusive single-item measures of SOCE and GICE. Second, the problem is intensified by the ill-advised incorporation of frequency rates derived from these items into multiplicative deductions that compound the "original sin" in an effort to generalize to the LGB and T national populations. Third, some of the numbers for the prevalence of persons identifying as LGBT may be at the higher end of the range for these statistics which, when combined with the over-inclusive prevalence figures for SOCE and GICE, produce exposure numbers that further the impression of a social crisis and urgent "health hazard."

The scholars and activists who purvey these prevalence statistics appear more than willing to create the impression that an astronomical level of LGBT exposure to the worst coercive and aversive behavioral interventions has occurred and is still taking place. Such claims are occurring four decades after such practices have ceased to be utilized by professionals to modify sexual orientation, even by therapists still willing to explore sexual attraction and gender identity fluidity with clients who request this. Tellingly, examples of specific therapeutic language that creates harm commensurate with the harms of the alleged aversive behavioral practices (and hence worthy of being banned) are never offered by these same scholars and activists. Furthermore, due to the imprecise measurement of SOCE and GICE, the prevalence figures derived from these surveys may well include a preponderance of ethical clinical and religious practices, such as emotional and medical cost/benefit discussions requisite for informed consent or exploratory psychosocial treatments, all administered through speech alone and perceived by respondents to be dissuasive and non-affirming.

Despite clear plausibility, it is of course not possible given the survey measurement limitations to be sure that such a low bar for what constituted SOCE or GICE was present in respondents' minds. Conversely, it is also not possible for the Williams Institute, the NCTE, or scholars such as Turban and his colleagues to be certain that such experiences *were not* construed by respondents as SOCE or GICE. Among all except committed activists, such and subsequent prevalence uncertainty can hardly be considered a scientifically responsible basis for legal prohibitions on client-centered, professional change-allowing and fluidity-exploring talk definitional therapies.

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A Critical Review of 2020 Research on Harms from Efforts to Change Sexual Attractions and Behaviors: Minimal Advancement of Science, Maximal Advancement of Agendas

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The following critique provides a critical examination of three recent empirical studies purporting to show evidence of harms from exposure to change-allowing therapies. Thirteen areas of methodological and definitional concern are presented to highlight the severely problematic nature of utilizing this research to support legal bans on SAFE-T in particular and contemporary change-allowing therapies generally. This analysis also briefly examines a model law for banning change-related practices, which identified some new developments in this ban template with special relevance to faith-based practitioners and organizations. Overall, these articles shed more light on the motives and aims of the authors' agendas than they provide scientifically based assistance in identifying specific sources of harm directly attributable to contemporary SAFE-T. Hence, these studies (like most before them) cannot be credibly employed to support the draconian infringements on professional and religious speech and practice dictated by current legislative bans.

Keywords: SAFE-T, SOCE, conversion therapy, research limitations, legal bans

The year 2020 has seen a significant expansion of the research base purporting harms from the pursuit of change in unwanted same-sex behaviors and attractions in a professional therapy or religious counseling setting. A literature base is being constructed by opponents of sexual attraction fluidity exploration in therapy (SAFE-T)[2]

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[2] I will employ the term SAFE-T when referring to contemporary change-allowing treatments generally but will use the terms "conversion therapy" (CT) and "sexual orientation change efforts" (SOCE) when referring to details of a specific article where the authors adopt such language.

that is widely believed to be laying a foundation to outlaw such therapies not only for minors in professional therapy contexts, but also for adults and for consumers in religious environments. In this critical review, I will examine three significant studies reporting harm from change-allowing therapies, first describing their findings and subsequently outlining several ways the studies are too methodologically compromised for making widespread claims of harm sufficient to justify the outlawing of professional and religious practice and speech. I follow this with a brief discussion of a recently developed template for therapy bans that appears to provide a strategic "game plan" that would prohibit SAFE-T in municipalities, states, and nations.

Findings from Recent Studies

Blosnich et al. (2020)

John R. Blosnich

Blosnich et al. reported analyzing data from 1,518 nontransgender sexual minority adults obtained through the Generations survey. Their stated intent was to examine how sexual orientation change efforts (SOCE) are associated with suicide morbidity after controlling for adverse childhood experiences (ACEs). Of the 7% of their sample who reported exposure to SOCE, 80.8% reported SOCE from a religious leader. After adjusting for demographics and ACEs, sexual minorities exposed to SOCE had nearly twice the odds of lifetime suicidal ideation, 75% increased odds of planning to attempt suicide, and 88% increased odds of a suicide attempt with minor injury compared with sexual minorities who did not experience SOCE. However, they did not find a significant relation between experiencing SOCE and suicide attempt with moderate or severe injury.

Meanley, Haberlen et al. (2020)

Steven P. Meanley

Meanley, Haberlen et al. found participants (n=1,156) who were included in a multi-city sample of men who have sex with men (MSM) enrolled in the Multicenter AIDS Cohort Study (MACS) who completed health surveys as a part of their biannual study visits. Multivariate regressions were used to examine the associations of prior conversion therapy (CT) with current depressive symptoms, internalize homophobia (IH), PTSD, and cumulative psychosocial conditions. Their sample was predominantly non-Hispanic white. They report 15% of the sample indicated prior CT exposure. Findings indicated men exposed to CT were more likely to have depressive symptoms and above-average IH. These participants also had 2–2.5 times the odds of reporting 1 and $\geq$ 2 psychosocial conditions, respectively. Resilience was not found to moderate these associations.

Salway et al. (2020)

Travis Salway

Salway et al. utilized a sample (n=8,388) of Canadian sexual minority men from the *Sex Now* survey from 2011 to 2012 with the intent of describing the prevalence, social-demographic correlates, and health consequences of SOCE among these men. Of this sample, 3.5% of participants reported SOCE exposure, which was higher among gay compared to bisexual men, transgender compared to cisgender respondents, those who were "out" about their sexuality compared to those not "out," Indigenous and other racial minorities as compared to White men, and those earning a personal income less than $30,000 compared with those earning at least $60,000. Exposure to SOCE was reported to be positively associated with loneliness, regular illicit drug use, suicidal ideation, and suicide attempt.

An Overview of Methodological Issues and Concerns

The findings from these studies all point to what their authors believe is a definitive conclusion: change-allowing therapies (including SAFE-T) are harmful. However, the following examination of this research instead suggests these studies may not have been exposed to sufficient critical scrutiny by the research teams and the journal reviewers. I note 13 areas of actual and potential concern.

1. Prejudicial Definitions of Change-Allowing Therapies

All of these studies set the stage in their introduction for what follows by defining SOCE or CT in highly prejudicial terms. Blosnich et al. describe SOCE as involving ". . . a variety of approaches such as immersion in heterosexual-focused cognitive therapy, amplification of shame for same-gender attraction, and physical punishment (e.g., electric shock) intended to condition against mental or physical attraction to the same gender" (p. 1024). Meanley, Haberlen et al. state, "Common forms of conversion therapy include aversion/shock therapies, gender norm policing, individual therapies, and religious-focused therapy" (p. 7). Salway et al. label SOCE as ". . . pseudoscientific practices intended to suppress or deny unwanted feelings of sexual attraction to members of the same gender/sex" (p. 503) and state,

> SOCE draw on a range of discredited methods including aversion therapy (e.g., electric shock), attempted desensitization to same-gender/sex erotic materials, psychodynamic therapy with a focus on etiology of the individual's sexuality, and religious approaches (e.g., prayer, Bible reading). (p. 503)

It appears from such caricatures of contemporary SAFE-T that these researchers are stuck in the 1960s and 1970s with little interest in updating their awareness of modern practitioners or practices. A less charitable but more likely characterization would be they are deliberately grooming readers with images of electric shocks and gay porn in order to solidify anti-change prejudice from the get-go. After all, who would not be against such horribly abusive practices, if only they *actually had* been

practiced by professionals in the past *four* decades. In a moment of refreshing candor, University of Utah College of Law professor Clifford Rosky, who developed a therapy ban bill in Utah, confided to the local gay press what these researchers suppressed:

> Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades. . . . What they do these days . . . was talk therapy. As we know, words are just as damaging to children. (2019)

In contrast to these misleading portrayals, a non-rhetorical and more objective depiction of the matter would say something to this effect:

> Decades ago, harmful aversion techniques such as use of electro shocks were utilized in attempts to change sexual orientation by many in the mental health professions. Evidence for the contemporary use of these techniques in change efforts is lacking. Some consumers have reported harm from more recent change efforts. The existent research does not provide definitive conclusions regarding to what extent harms are attributable to the change efforts, what specific change efforts may lead to harm, and how valid it is to generalize from these studies to the population of sexual minorities as a whole, including those who do not identify as LGBT.

2. Questionable Validity of Studies Cited to Depict Change-Allowing Therapies as Universally Harmful

All of these studies make the case for SAFE-T as a serious health hazard for clients by referencing studies known to have significant limitations in their ability to generalize beyond their samples. Blosnich et al. reports negative outcomes from SOCE to include ". . . increased distress, depression, hopelessness, and suicidal thoughts and behaviors" (p. 1024). In support of this conclusion, the authors cite only four articles, which one might assume would provide evidence they believe is the most conclusively indicative of harm. However, two of the studies are Flentje et al. (2013) and Shidlo and Schroeder (2002)—research that has serious limitations. Another of these citations is a survey from the Trevor Project (2019), an activist organization which is not known for being non-partisan.

Not surprisingly, Meanley, Haberlen et al. make similar claims about CT's harms of increased depression, suicidality, and IH. They reference Shidlo and Schroeder (2002) as well as Bradshaw et al. (2015) and Ryan et al. (2020). Finally, Salway et al. report SOCE to be ". . . associated with numerous negative health outcomes including self-hatred, depression, and suicidal ideation and suicide attempts" (p. 503). The authors support this contention by citing four studies (can you guess which ones?): Shidlo and Schroeder, Ryan et al., Flentje et al., and a report from another activist group, Movement Advancement Project (2015), who advocate for broad therapy bans. Later in the article Salway et al. provide only the Ryan et al. and Flentje et al. studies to support their blanket claim that SOCE is associated with ". . . loneliness, substance use, depression, anxiety, suicidal ideation, and suicide attempts" (p. 505). I have enumerated the serious limitations of most of these studies previously (Rosik, 2014; Rosik, 2019a, 2019b), and interested readers can examine these writings for a critical analysis of this literature. I am struck by how prior studies with severe methodological limitations are used as support by current studies with similar deficiencies to produce sweeping

conclusions to support expansive therapy bans. As I have noted before, using this literature to comprehend SAFE-T makes as much sense as studying former marital therapy clients who have since divorced to understand the harms and effectiveness of marital therapy. In what appears to be an ideological echo-chamber within which these researchers exist, one is left to wonder to what degree, if any, these researchers are exposed to alternate perspectives that could help them see their confirmation bias and exert a much needed scientific circumspection.

It is also worth mentioning in this discussion that all of these studies reference the Williams Institute report (Mallory et al., 2018), either by citing the estimates from the report of 700,000 people being exposed to SOCE (Meanley, Haberlen et al.; Salway et al.) or by analyzing data directly from the Generations survey on which the report is based (Blosnich et al.). I have observed in another review (Rosik, 2020a, this issue) the likelihood of significant overestimation of exposure to any meaningful definition of SOCE and the clear evidence of ideological bias in the report's conclusions. Overall, there appears to be a kind of unspoken template for how to introduce the issues whenever SOCE is studied, and to go against this orthodoxy no doubt limits the chances researchers have for publication on the topic in most journals.

3. Reliance on Gay Identified Samples

A growing concern with the literature on change-allowing therapies is the overwhelming reliance on sampling of non-heterosexual persons who identify as gay, lesbian, bisexual, transgender, and other sexual minority identities who are typically surveyed through LGBT-identified venues and networks. The present research studies are no exception to this rule. Blosnich et al., as noted above, utilized the Generations survey, whose eligibility criteria for involvement in the study included the identification as LGB, queer, or same-gender loving. Salway et al. obtained their data through *Sex Now*, an online survey of sexual minority men in Canada recruited from LGB venues, ". . . including dating and sex-seeking websites, social media, community organization newsletters, a database of previous study participants, and word of mouth" (p. 504). As could be expected, this recruitment approach resulted in a sample where 96.9% of participants were gay or bisexually identified. Finally, Meanley, Haberlen et al. indicated that 89.4% of their sample identified as gay men. They also noted that the 10.8% of original participants who did not provide complete responses and were therefore excluded from the analyses were significantly more likely to have indicated a non-gay identity.

This is problematic in that recent research is suggesting that LGB-identified persons and those with SSA who reject an LGB identity are not equivalent groups of sexual minorities and likely have different patterns of religious belief and practice, sexual practice, and even experiences of change-allowing therapies (Lefevor et al., 2020; Rosik, 2020b). Those not LGB-identified, compared to those adopting LGB identities, tend to report being more traditionally religious, more actively religious, less engaged in same-sex behavior, more single and celibate or in a heterosexual relationship, and more likely to report most change-oriented goals as being helpful. This plausibly has created significant misrepresentation of those rejecting an LGB identity undiscoverable by research such as that under scrutiny in this analysis. The potential size of this lacuna within organized psychology begs for there to be greater attention paid to this minority within a

minority as therapy bans expand in scope and jurisdiction.

4. Additional Sampling Concerns

Apart from failing to capture non-LGB-identified sexual minorities, these studies have other limitations that make generalizing beyond the samples highly questionable. For example, Meanley, Haberlen et al. and Salway et al. excluded women entirely, which at the very least should limit generalizations about change-allowing therapies from these studies to men. Although Meanley, Haberlen et al. thankfully did not recruit on the basis of LGBT identity they obtained data from the Multicenter AIDS Cohort Study (MACS), an ongoing study of men where eligibility is limited to men who have had any sexual intercourse with another man since enrolling in the MACS. Not surprisingly, they reported that 49.1% of their sample was HIV+. These authors cite an early study from this project, which gives some indication of the sexual activity of this cohort (Kaslow et al., 1987):

> Nearly 5,000 homosexual men volunteered for semiannual interview, physical examination, and laboratory testing in four metropolitan areas. A significant majority of these men in each center (69–83%) reported having 50 or more lifetime sexual partners, and over 80% had engaged in receptive anal intercourse with at least some of their partners in the previous two years. (p. 310)

Again, such sample characteristics likely eliminated consideration of many sexual minorities who might report benefit from SAFE-T, since these individuals tend to be more religious and often have limited same-sex experience (Lefevor et al., 2020; Rosik, 2020b).

Meanley, Haberlen et al. additionally reported 29.8% of their sample indicated "limited decision-making power" regarding the initiation of therapy, which may indicate they were minors at the time forced by parents to go to psychotherapy or religious counseling. Should this be a marker of coercion, then this further brings into question the validity of generalizing from this sample to contemporary forms of SAFE-T, which is non-coercive and client-centered by definition. Finally, Meanley, Haberlen et al.'s sample consisted of older gay men who reflected upon their past experience of SOCE, which raises a further concern worthy of its own section.

5. Retrospective Reports

The problem of potential recall bias has been universal in this literature to date, and these studies prove no exception. Blosnich et al.'s use of the Generations survey means that participants were reported on SOCE experiences decades earlier (Rosik, 2020a, this issue). Interestingly, they acknowledge that participant reports of ACE exposure may be prone to recall bias (p. 1029), but do not offer this as a concern for reports of SOCE. Salway et al. note 78.3% of participants exposed to SOCE had been exposed more than 12 months ago and 61% of the entire sample were age 40 or older. This suggests their participants were recalling SOCE from years and often decades prior to the study. Meanley, Haberlen et al.'s study of midlife and older men lent itself specifically to recall concerns, which the authors specifically mention as a limitation. And with good reason. The average age of their full sample was 62.6 years (SD=8.6) and among those exposed to SOCE, the average age beginning SOCE was 23.8 years (SD=10.2). Prior SOCE was also found to be significantly

more prevalent among older participants. Hence, it is exceedingly probable that most SOCE experiences being recollected had occurred nearly four decades ago. What this great lag time means is that the SOCE practices being evaluated are those from the ’70s and ’80s, which bear little resemblance to the practices of therapists who explore sexual attraction fluidity with their clients today. It is questionable to call for bans on contemporary psychotherapy practices that may well bear little resemblance to what these men went through.

The recollection of such distant experiences is fraught with peril, as the APA (2009) Task Force Report noted: “People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall” (p. 29). It is noteworthy that Meanley, Stall et al. (2020) dismiss these concerns in a study using the same dataset, stating, “. . . we argue that our analyses are warranted based on considerable evidence that demonstrates the enduring salience of shame that arise from traumatic experiences” (p. 338). This dismissal comes despite the relative uniqueness of their sample and the fact they neither assessed nor controlled for shame, PTSD, and aversive childhood experiences (ACEs). Surely the authors would treat positive or neutral reports of CT that were four decades old with immense skepticism.

6. Confounding Effects of Childhood Trauma

Neither Salway et al. nor Meanley, Haberlen et al. reported participants’ experience of childhood trauma. Such data may not have been available in the dataset employed by Salway et al., but regardless, this possible confounding covariate seemed to be of no interest to the authors of both studies in considering the associations of SOCE with harms. As is common in the literature, this plausible limitation is conveniently ignored. In fact, Meanley, Haberlen et al. even mention in their discussion the associations found among sexual minorities in a prior study using the MACS dataset between long-term depressive symptoms and “sexuality-related victimization in formative years.” This suggests that childhood sexual victimization was an available but unutilized variable to be included by Meanley, Haberlen et al. if they had been so inclined. It appears from their writing the authors only consider SOCE to be a form of childhood trauma leading to harms and hence fail to explore the less “affirmative” view that pre-therapy childhood trauma experiences may in fact account for the harms attributed to SOCE.

By contrast, Blosnich et al.’s study is one of the few to actually try to account for childhood trauma and makes the case that the effects of exposure to SOCE cannot be attributed simply to such events. Unfortunately, their operationalization of their trauma variable is done in such a manner as to bring their findings into serious question. The main issue is that these researchers used an additive total of aversive childhood events (ACEs) as their measure of ACEs in their regression models. However, inspecting their Table 2 examining ACE’s and SOCE exposure for each specific type of traumatic experience yields a critical insight: the sum of the ACEs of the SOCE group was not composed of the same ACEs as the non-SOCE group, and not all ACEs have the same effect on suicidality. The SOCE and non-SOCE groups did not differ on experiences of household substance use, parental separation or divorce, parental mental illness, and incarcerated household member.

However, the SOCE group experienced a very different distribution of ACEs than the non-SOCE group in regard to significantly greater exposure to parental violence and

emotional, physical, and sexual abuse. Specifically, the SOCE group was three times more likely to have experienced sexual abuse and twice as likely to report experiencing physical abuse and violence between parents. These latter traumatic experiences interact to produce even stronger risks, if someone experiences more than one of them (Fuller-Thomson et al., 2016). This level of risk is more than sufficient to account for the increased risk of suicidality among the SOCE group. Had the authors adjusted their models for this difference in ACE distributions between their sample groups rather than simply utilize the sum total of ACE categories reported by participants, it would likely have accounted for the difference in risk, conceivably even resulting in a lower suicide risk among the SOCE group.

7. Lack of Adequate Comparison Groups

All three of these studies attribute harms to change-oriented practices on the basis of contrasts between a SOCE or CT exposure group and a comparison group. Meanley, Haberlen et al. compare lifetime CT exposure group with a no CT exposure group. Salway et al. has a similar contrast between SOCE exposure and no exposure groups. Blosnich et al. report differences between participants who experienced SOCE and those who did not. This may appear convincing to those predisposed to finding harm from such experiences, but in truth these comparisons are quite insufficient and potentially misleading. What is needed and not provided is a comparison group of participants who experienced therapies that *did not* involve SOCE. Only with such a comparison can we really obtain any insight into the degree participants involved in therapy *in general* constitute a distressed group whose reports of emotional and behavioral problems may have pre-existed before SOCE rather than were caused by it. To their credit, but with little fanfare, Blosnich et al. at least acknowledge this issue: ". . . we could not examine the relationship of non-SOCE mental health treatments, ACEs, and suicidality" (p. 1029).

8. Single Item Measures

Each of the studies under examination utilized a single item measure to assess for exposure to SOCE or CT. The *Sex Now* survey utilized by Salway et al. asked participants, "Have you ever attended sexual repair/reorientation counseling?" with response options being "no," "some time ago," "last 12 months," or "both prior to and last 12 months." The Generations survey employed by Blosnich et al., asked participants, "Did you ever receive treatment from someone who tried to change your sexual orientation (such as try to make you straight/heterosexual?" Response options were "no," "yes, from a health care professional (such as a psychologist or counselor who was not religious focused)," and "yes, from a religious leader (such as a pastor, religious counselor, priest)." Meanley, Haberlen et al. reported their CT item asked participants to indicate whether they had ever undergone conversion therapy to change their sexual orientation." Response options were "no" and "yes," and "yes" responders were provided a battery of items to specify the types of therapies undergone (e.g., psychotherapy, group-based therapy, prayer/religion-based therapy, gender role reinforcement, aversion therapy, pharmacological treatments).

Although single-item measures have their role, particularly in exploratory research, they are not without significant limitations in light of the aim of these researchers to support change-allowing therapy bans. These measures of SOCE are fraught with validity concerns, for being non-specific as regards to "treatment," "tried to change," "try to make,"

"conversion therapy," or "repair/ reorientation counseling" and hence impossible to interpret definitively. Such "treatments" could run the gamut from harmful aversive practices to generic prayers for healing or discussions of religious moral teaching. We cannot know what participants envisioned and thus the authors can have no real understanding of the source of their findings. This state of affairs is acknowledged, in a rather understated manner, by Blosnich et al.'s comment that, "Our measure of SOCE is limited in that it does not differentiate among the diverse experiences SOCE people may have had" (p. 1029). They further note, "The Generations survey team developed the SOCE measure, and although it seems straightforward, no evidence of the measure's validity and reliability exists at this time" (p. 1029). In other words, we cannot be sure what we think we are measuring really is what is being measured or that it measures the same thing across participants.

Meanley, Haberlen et al. attempt to provide more specificity, finding CT occurred in psychotherapy for 67.3% of participants reporting CT exposure. Group-based psychotherapy was the next most reported form of CT at 39.2%, followed by prayer/religion-based CT at 30.4%. Tellingly in light of the aforementioned ubiquity of including damaging aversive techniques in contemporary definitions of CT, even in Meanley, Haberlen et al.'s older age sample, only 4.1% reported ever experiencing CT that included aversion techniques. Although these findings are of interest, they do not solve the problem of what specific techniques and practices constituted CT. Hence, even if the findings were valid, they would only support an empirical basis for the most nebulous and overreaching prohibitions on professional therapy and religious practice. This is how it has become possible for judges to equate preventing trans girls from competing in biological girls' sports with conversion therapy (M. Sharp, personal communication, August 31, 2020).

It is also worth observing that such lack of specificity, when used in research that purports to *support* the facilitation of change through therapy, is grounds for having studies retracted on the basis of statistical concerns. Case in point is the Santero et al. (2018) paper retracted by *Linacre Quarterly*, which was withdrawn for three reasons, the first two being:

> 1. No common intervention was given to participants that would allow for a valid conclusion to be drawn.
>
> 2. The paper did not establish a demonstrated relationship between the intervention and the survey that measures the intervention in that the paper did not clearly address whether all respondents were treated according to the same (or similar) protocols and for the same periods of time, and/or by therapists of like or similar training and expertise. ("Retraction Notice," p. 108)

Details concerning the questionable rationale for this retraction have been offered elsewhere (Retraction Watch, 2019; Whitehead, 2019), but for the present purposes it is enough to observe that these reasons for retraction would also appear to apply to the non-specific and hence non-standardized definitions of SOCE or CT in the research considered here. This is yet another example of the glaring lack of evenhandedness in the evaluation of alleged harms and benefits from change-allowing therapies dating back to the APA Report (American Psychological Association, 2009), wherein the methodological standards are exceedingly more rigorous for claims of benefit than they are for assertions of harm (Jones, Rosik, & Williams, 2010).

One final source of non-specificity is the potential confounding involved in lumping change-allowing professional psychotherapy with unregulated religious approaches to change. It needs to be emphasized that none of these three studies can distinguish between religious and licensed therapists, Salway et al. because their item did not make such a differentiation and Meanley, Haberlen et al. and Blosnich et al. because they chose to combine into a single category those who experienced change-oriented practices facilitated by either or both types of providers. This further limits their ability to generalize findings given the plausibility of differential outcomes between provider types.

9. The High-Low Fallacy

Consumers of the literature on change-allowing therapies need to pay special attention to the presence of the high-low fallacy. This fallacy occurs when researchers interpret small but significant differences at one end of a scale as if the differences reflect values at the scale endpoints (Reyna, 2018). An example of this fallacy is found in Meanley, Haberlen et al.'s treatment of their findings on internalized homophobia (IH). These researchers claim in their discussion that CT contributes to psychosocial health inequality among men having sex with men in part because of its association with greater IH. However, the distribution of IH in the sample was reported to be right skewed with only 15.5% of participants having above-average IH. This raises the likelihood of the high-low fallacy coming into play, i.e., the comparison is actually between those who are very low in IH with those who are moderately low in IH, but it is represented as a contrast between a low IH non-SOCE group and a high IH SOCE group.

This is why it is so important when reading this literature to carefully examine how variables are scaled, the norms of scales utilized, and where group means fall relative to these scales and their norms. Accurate interpretation of the findings may hinge on comprehending this context.

10. Causality Is Assumed from Correlational Data

All of the studies in question are correlational in nature and involve convenience samples obtained at a single point in time for each participant. This is tacitly or explicitly conceded by these researchers. Blosnich et al. confess, ". . . our measure did not allow us to accurately time SOCE experiences as they related to ACEs exposure" (p. 1029). Meanley, Haberlen et al. grant their retrospective data only permit them to argue for CT as a "contributing," rather than "causal," factor for negative psychosocial health, although this has the appearance of a distinction without a difference. Salway et al. specifically eschew causal interests, stating, ". . . our objective was to describe the demographic and psychosocial profile of those exposed to SOCE rather than identify causal effects" (p. 504). Despite being cognizant of the inappropriateness of attributing harms to change-oriented therapies, these researchers lapse into causal statements in their discussions with some regularity.

Salway et al. infer SOCE causes harms on a questionable basis: "We are unable to know whether SOCE preceded the psychosocial health outcomes identified by participants; however, reverse causation is unlikely given that the major drivers of seeking SOCE correspond to environmental attitudes—for example, family religiosity—rather than intraindividual factors" (p. 507). Similarly, Blosnich et al. noted that 80% of those seeking SOCE did so in a religious setting. It is conceivable that participants raised in a strict religious setting experienced greater

distress due to the incongruence of their sexual minority status with their religious ideals and not from the SOCE itself. In fact, Blosnich et al. and Salway et al. use their findings to criticize the religious basis of much SOCE exposure, implicitly acknowledging this association, while apparently remaining blind to the possibility of an independent effect of strong familial religiousness on sexual minority distress and suicidality.

A plausible alternative hypothesis to putative causal effects of SOCE on suicidality is that those seeking treatment are a more distressed group at the outset of their clinical presentation. The attribution of increased suicidality to SOCE is quite speculative without a non-SOCE treatment group and a longitudinal design, features that are in very short supply in this literature. Most ACEs reported by Blosnich, which by definition took place before age 18, and in the case of sexual abuse (the ACE most strongly associated with SOCE) before age 13, would likely have taken place before the SOCE attempts. Given that a third of the sample were over age 51, it is quite possible, even likely, that some of the suicidal behavior preceded the SOCE. Hence, it seems very reasonable to believe experiencing suicidal behavior caused many participants or participants' parents such concern they sought out SOCE, and not the other way around.

Blosnich et al. also reported LG-identified participants were more likely to report experiencing SOCE than bisexually identified respondents or respondents with other sexual minority identities (e.g., queer, pansexual). Yet all but one measure of suicidality was higher among bisexual and other sexual minority respondents than it was among LG participants. Suicide ideation and planning were both higher among non-LG participants, significantly so for other sexual identities who were at about twice the risk than the LG participants. Contrary to Blosnich et al.'s conclusions, suicide risk was higher among those less exposed to SOCE.

Despite the clearly indeterminate causal nature of the findings from these studies, the very opposite is frequently implied. Meanley, Haberlen et al. opine their findings support CT as a sexual minority stressor that "contributes" to psychosocial health inequality, which only supports their policy recommendations if it infers causality. Citing studies that suffer from the same causal uncertainties, Blosnich et al. assert their findings add to the research showing SOCE "may compound or create problems" and describe ". . . SOCE as a stressor with particularly insidious associations with suicide risk" (p. 1027). All of these researchers view their findings as adding further weight to therapy bans, which in itself is grounds for believing they make a causal connection between past exposure to change-allowing therapies and current emotional distress. In actuality, as outlined earlier, these studies build off of earlier studies that suffer from many of the same serious limitations that should preclude definitive statements of causality. As concerns contemporary SAFE-T then, this oppositional research is a house of cards built upon a house of cards.

11. Underwhelming Effect Sizes

In general, when considering the key Odds Ratios (ORs) and Risk Ratios (RRs) provided in these studies, the findings appear not to be as striking as they are touted to be. Meanley, Haberlen et al. report adjusted ORs of 1.72, 1.55, and 1.38 for associations of CT exposure with depressive symptoms, IH, and PTSD, respectively. Blosnich et al. found adjusted ORs of 1.92, 1.75, 1.88, and 1.67 for suicidal ideation, suicide planning, suicide attempt with no/minor injury, and suicide attempt with moderate/severe injury, respectively. Salway et al. observed RRs of

1.83, 1.06, 2.71, 1.42, and 2.49 with loneliness, regular binge alcohol use, regular illicit drug use, ever having suicide ideation, and ever attempting suicide, respectively. Given that ORs/RRs of 1.68 have been estimated to reflect small effects and 3.47 to reflect medium effects (Chen, Cohen, & Chen, 2010), it is evident that these results can at best be interpreted as displaying no effect in a few cases or small to somewhat below medium effects for the other variables. Moreover, several of these ratios have 95% confidence intervals that include or almost include zero, the point at which there is presumed to be no effect. These include the association of SOCE with (1) depressive symptoms, IH, and PTSD (Meanley, Haberlen et al.); (2) suicide planning, suicide attempts with no/minor injury, suicide attempt with moderate/severe injury (Blosnich et al.); and (3) regular binge alcohol use (Salway et al.). Hence, these findings were at best barely significant, despite the fact the datasets were very large. It is also worth noting from Blosnich et al. that the adjusted OR for the association between childhood sexual abuse and SOCE is 2.95, a larger effect than for any of the associations with SOCE and suicidality.

Schumm (2015) has recommended that research results meet a certain standard before being deemed adequate to be considered in policy and judicial decision-making. These standards limit such consideration to studies that (1) have at least medium effect sizes; (2) use random samples from known populations; and (3) employ reliable and valid independent variables. By these reasonable standards, the studies being examined in this analysis make *at best* a very modest contribution to the literature.

12. (Not So) Hidden Agendas

Given the modest and less than equivocal conclusions that can be drawn from these studies, the sweeping scope of the policy recommendations these researchers support with their findings is breathtaking. Meanley, Haberlen et al. conclude their results support organizations that "denounce" CT as "unethical" based on the potential danger posed by CT practices, even though they do not know the specifics as to what these practices actually are. Blosnich et al. are perhaps slightly more subdued, but nevertheless still advocate that, "Greater awareness of the harms of SOCE need to be conveyed to the general public, especially in areas that may have a greater prevalence of professionals who engage in SOCE" (p. 1029). Salway et al., meanwhile, offer perhaps the most draconian application of their findings. They bemoan the fact that "denouncements" by professional bodies have not brought the practice of SOCE to an end. Citing existing bans, they urge the Canadian government to eradicate SOCE, which ". . . may require an amendment to the criminal code as well as other multilevel legislative actions" (p. 507).

Elsewhere, Salway (2020) has written more pointedly about his objections to SOCE:

> To effectively prevent conversion therapy, legislative bans must adjust their definitions to clearly state that the defining feature of conversion therapy is not an attempt to "convert" or "change" intrinsic feelings of gender identity or expression or sexual orientation. Rather, the defining feature is the goal of avoiding acceptance and acknowledgement of LGBTQ2 lives as compatible with being healthy and happy. . . . That sense of self is what is fundamentally at stake in the debates over conversion therapy.

In this vision, there is only one way for sexual minorities to find health and happiness, and Salway is so confident it is his way he is willing to advocate for the outlawing of all other potential paths.

These clear and dramatic policy exhortations, based on such generally equivocal findings, seem to betray an enthusiasm on the part of these researchers to obtain findings more in line with their policy objectives than with a nuanced discernment of scientific realities concerning change-allowing therapies. In fact, the organization behind the *Sex Now* survey utilized by Salway et al. is pretty open about this, stating its ". . . findings are being shared early to inform immediate policy action—including the proposed federal conversion therapy ban" (Community-Based Research Center, 2020). It is hard to shake the feeling that there is a certain disingenuousness present in the appearance of scientific objectivity with these studies.

13. Traditional Religion in the Crosshairs

There is no mistaking from these studies that all the authors view traditional religious belief and practice as a serious problem in need of fixing. Meanley, Haberlen et al. suggest existing therapy bans with minors become federal law and be expanded to include language prohibiting *anyone*, including non-licensed professionals, from practicing CT. Blosnich et al. express concern that,

> . . . existing laws do not apply to adults or SOCE administered through religious leaders. This religious exemption is particularly concerning because among the sexual minorities in this sample who experienced SOCE, 4 of 5 people received it from a religious provider. (p. 1029)

Salway et al. share a concern regarding religiousness only in alluding to the danger of family religiosity as a risk factor for harm. However, prior to his study being published, he defined CT practices as relying ". . . upon a variety of methods, including coaching, counseling, therapy, *prayer*, and conversation" (Salway, 2020; emphasis added). There appears to be little doubt as to the direction this movement to ban change-allowing therapies is headed, and traditional faith communities can no longer afford to look away.

Salway et al. refer singularly to a model law—a favored template for legislative therapy bans—they believe is worthy to be enacted. Because this model law may give some indication where ban proponents are headed, I felt this model would be worth a short overview and comment in the context of critiquing studies purported to support such prohibitions.

A Proposed Model Law for Prohibiting SAFE-T

The model law endorsed by Salway et al. is the creation of Ashley[3] (2019a).

[3] Ashley is reportedly completing studies for a Doctor of Judicial Science at the University of Toronto. Ashley self-identifies as a transfeminine jurist and bioethicist, public speaker, and activist who uses they/them and gay/ghem pronouns. Ashley also noted an identity, metaphorically, as a biorg witch with flowers in her hair. Given that my only prior use of they/them pronouns with an individual has been in clinical situations involving Dissociative Identity Disorder, I chose to avoid this implication in the text by referring only to this person's listed surname.

Florence Ashley

In this document, Ashley provides an outline of the model law (pp. 7–12) followed by a detailed section of explanatory notes (pp. 12–45). The first subsection of these explanatory notes provides a detailed definition of conversion practices (identifying disallowed and permitted practices), as well as defining cause of action and pursuable damages. The interested reader should examine the source material directly, but here I will highlight several important aspects of this model law.

Definitions

No Longer Described as "Therapy"

The model law does not use the language of "conversion therapy" or even sexual orientation change efforts. Instead, it tries to be more descriptive in that it refers to "conversion practices," which is "any treatment, practice, or sustained effort" toward change (more on this aspect later). Sexual orientation but also gender identity, gender modality, and gender expression or behaviors are forbidden foci of change. The reframing of the model law around the terminology of conversion practices is done ". . . for reasons of recognizability, intelligibility, and coherence and to avoid the positive connotations associated with therapy (and other terms such as 'reparative'), which may be inappropriate in the context of unethical and harmful practices" (pp. 12–13).

Forbidding Discussions of Etiology

Noteworthy is the model law's declaration that discussions about causation of same-sex attractions or gender dysphoria are off limits. Ashley writes that forbidden conversion practices include, "Treatments practices, and sustained efforts that have for primary aim the identification of factors which may have led to the person's sexual orientation, gender identity, gender modality, gender expression or behaviors associated with a gender other than the person's sex assigned at birth, unless in the context of research which has been approved by an institutional review board" (p. 7). Perhaps this is meant to target outlier instances of counselors searching endlessly for memories of childhood trauma in an effort to "treat" same-sex attractions when the sexual minority client has not expressed an interest or desire for this. Unfortunately, the law as written does not distinguish between therapist-initiated and client-initiated examinations of etiology, and clients often present with views about what has led to their unwanted same-sex attractions.

It would appear from the language of this law that clients who present with a belief that childhood trauma has factored into their same-sex attractions and want to address their trauma history in relation to their attractions in psychotherapy or pastoral care would be engaging in prohibited conversion practices. Forbidding such discussions would be a remarkable truncation in the scope of psychological practice surround sexual orientation and gender identity and signal the forced muzzling of a historically central pillar of psychotherapy, i.e., the pursuit of insight and understanding into one's condition. To this extent, the law would mandate therapists' abdication of their professional responsibility.

Intrusion into Parenting

The model law explicitly undermines parents' rights, leaving therapists and counselors vulnerable to legal action if they recommend to parents any restrictions on

their child's expression of sexual orientation or gender identity. Outlawed would be

> treatments, practices, and sustained efforts that direct parents or tutors to set limits on their dependents' gender non-conforming behavior, impose peers of the same sex assigned at birth, or otherwise intervene in the naturalistic environment with the aim of repressing, discouraging, or changing the dependent's sexual orientation, gender identity, gender modality, gender expression or any behaviours associated with a gender other than the person's sex assigned at birth." (p. 7)

Cringe-worthy scenarios are not hard to imagine. What are therapists to tell parents whose sexual minority teenager is acting out in dangerous or dramatic ways (e.g., pursuing same-sex sexual contact in the home or demanding breast binding or cross-sex hormones)? Under this law, it appears they can only respond, "I am legally prohibited from suggesting you place any limits on your teen's same-sex behavior and gender expressions."

Misnaming Mishaps

Under Ashley's proposed law the authority of the pronoun police is fully vested. Explicitly prohibited are "treatments, practices, and sustained efforts that knowingly use names, pronouns, gendered terms, and sexual orientation terms other than those chosen or accepted by the person, except as required by law" (p. 8). Of course, reasonable sensitivity to the individual's preferences is good practice, but this language surely opens up a can of worms. What Ashley ignores is the certain risk that even well intention clinicians will be held hostage to the law, not having any clear definition of what a "sustained effort" to misname looks like to the sexual minority client. Since the ultimate arbitrator of the meaning of terms in the law *is the client*, who could be very disturbed and rejection sensitive, it is frighteningly possible for ethical therapists and counselors to end up having to fight legal/professional action instigated by disgruntled clients under this law.

Conversion Practices by Another Name

The model law identifies several names of practices that qualify as conversion practices:

> Conversion practices, conversion therapy, reparative therapy, corrective therapy, the corrective approach, the (psycho)therapeutic approach, ex-gay therapy, reorientation therapy, reintegrative therapy, gay cure therapy, sexual attraction fluidity exploration in therapy, the pathological response approach, intersex surgeries and/or interventions, intersex genital mutilation, surgeries or interventions on disorders of sex development, genital normalizing surgeries and/or interventions, and sexual orientation (and/or gender identity) change efforts are all terms that been used to refer to conversion practices. (p. 12)

It is perhaps a complement to find the Alliance's preferred terminology, sexual attraction fluidity exploration in therapy (SAFE-T), appearing in this academic literature, even if it is done so in a manner that shows no real understanding of the term. Nor does Ashley appear to be aware of the legal risks taken by using unfavorably and without permission terms under copyright, i.e., reparative therapy and reintegrative therapy. I also was a bit surprised to see the term "disorders of sexual development,"

which includes the intersex condition, since advocates of these laws tend to be generally unwilling to use the language of disorder for nearly all sexual conditions, preferring to see them as normal variants of human sexuality. Such an all-inclusive grab bag of names for conversion practices, one that even includes SAFE-T, tells me once again that what is actually in focus is the goal of change, with any practices deemed to be associated with such a goal being suspect.

Legal Codification of a Moral Imprimatur

One of the more insidious aspects of this model law is Ashley's obliviousness to its deep encroachment into the philosophical and especially moral realms. The law fundamentally introduces a new moral orthodoxy within the legal and psychotherapeutic domains without any reflection on the significance of such an imposition. Consider this description of the forbidden underpinnings of change-allowing practices: "Treatments, practices, and sustained efforts that proceed from the assumption that certain sexual orientations, gender identities, gender modalities, or gender expressions are pathological or *less desirable* than others" (p. 7; emphasis added). This language of desirability is used throughout the document in this fashion, without recognition that the desirability of any trait or characteristic is necessarily a moral category of evaluation (i.e., desirable being good and undesirable being bad).

The model law thus dictates what moral appraisal regarding same-sex behavior and gender identity expressions therapists and their clients can make. Since psychology as a field has no greater authority to prescribe morality than does religion (and one can make an argument that religion has greater authority than psychology), Ashley's law in this regard undertakes a religious-like function by decreeing the desirability of same-sex behavior and non-binary genders. This becomes a powerful and legally threatening means to enforce the new moral orthodoxy through a legal imprimatur. Clinicians become unwitting agents of moral enforcement with their clients, and even adult clients with unwanted same-sex attraction or gender identities must adhere to the government mandated moral position within the context of psychological or pastoral care. Such patronizing governmental disregard for psychotherapeutic and religious freedom is particularly difficult to stomach when the scientific literature behind legal bans is so far from being definitive.

Punitive Measures

The model law is unambiguous and expansive when it discusses the types of ethical or criminal offenses practitioners will risk by engaging in several activities related to SAFE-T.

Providing Services or Referrals

"Any person who engages in conversion practices or knowingly refers an individual to someone who engages in conversion practices has committed an act of negligence" (p. 10). The inclusion of referrals in this definition of negligence is an expansion of the scope of such laws, moving beyond clinician practices to also include making referrals to them as well to church or parachurch organizations that are deemed to be non-affirming. This significantly broadens the scope of negligence and almost certainly creates much more liability for religious leaders, who in my experience are primary referral sources for clients and parents.

Advertising

Also included within the jurisdiction of this model law is the marketing and publicizing of SAFE-T: "Any person who advertises or receives compensation in exchange for engaging in or teaching

conversion practices has engaged in unfair or deceptive trade practices" (p. 10). This statement appeals to consumer fraud laws, an increasingly favored aspect of ban legislation, as it establishes in one swoop prohibitions of SAFE-T for all ages and for both professional and religious settings.

Unprofessional Conduct

Language common to most ban legislation is also found in the model law, threatening therapists with loss of licensure. "Any licensed or certified professional who engages in, teaches, or advertises conversion practices has engaged in unprofessional conduct and shall be subject to discipline by their licensing or certifying board" (p. 10). What is somewhat new in this provision is the language concerning "teaching" such practices. This leaves open the potential for licensed counselors on church staffs who offer traditional religious instruction about sexuality and gender to be consumer fraud, potentially even when there is no direct fee-for-service. Would church giving constitute compensation to such staff counselors and make this provision of the law actionable against them if they teach non-affirmative beliefs? Does religious teaching that same-sex behavior or non-binary gender identities are sinful or otherwise undesirable when imparted by these counselors constitute fraud? The answer to these questions would likely be determined in the judicial system. Yet given the unpredictability of the courts, there is no reason to feel confident licensed or certified church staff counselors would not be as exposed as licensed clinicians outside of religious settings under this provision of the law.

Organizational Liability

The most novel addition to the model law is its specific targeting of organizations and government agencies.

> It is illegal and constitutes an act of negligence for any organization or governmental entity to:
>
> a. Engage in or refer an individual to practitioners of conversion practices;
> b. Provide health coverage for conversion practices;
> c. Provide a grant or contract to any entity that engages in or refers individuals to practitioners of conversion practices; or
> d. Refuse to provide a grant or contract to any entity for refusing to engage in, teach, or advertise conversion practices.
>
> Organizations and governmental entities shall take reasonable steps to ensure compliance with sections [a to d]. (p. 11)

Although the provision reads as if government agencies and functions may be its primary focus, make no mistake that church and parachurch ministries would fall under the definition of "organization." In fleshing out what is meant by organizations, Ashley states, "The section extends the prohibition of conversion practices to legal persons other than natural persons, as organizations may be involved in the provision of conversion practices, especially in the context of unlicensed, faith-based practices" (p. 42). Given this understanding, it is impossible not to envision traditional faith communities and faith-based organizations being subjected to legal action under such a law.

Damages

The model law stipulates a cause of action: "Anyone who suffers harms or losses, including non-monetary, due to a breach of

[prior provisions] may bring a private action against the perpetrator under this act to enjoin further breaches, or to recover the damages sustained as a result, or both" (p. 11). This provision grants a civil cause of action to those subjected to conversion practices and enables them to pursue injunctive relief and/or recover damages. In other words, it makes sure those alleging harms have a right to sue. Ashley adds, "Since the harms of conversion practices may be difficult to quantify and go beyond monetary losses, it is crucial to enable the recovery of general damages for non-monetary losses" (p. 43). These non-monetary losses include ". . . pain, mental distress, loss of enjoyment of life, and harm to dignity. . . ." Such a low and broad bar for what constitutes harm certainly makes this provision a not-so-thinly-veiled encouragement to sue. "Because the purpose of laws prohibiting conversion practices is both to enable compensation for harm and losses suffered as well as discourage the practices themselves, allowing and *encouraging* punitive damages is legitimate" (p. 44; emphasis added; see also Ashley, 2019b).

Awardable damages granted under this model law include attorney's fees and costs as well as unspecified and therefore unlimited punitive damages. The law also proposes a statute of limitations of 10 years once the claimant has reached the age of majority. Of note is the apparent exclusion of organizations and government entities from this statute.

Other Stipulations

A few other aspects of this model law are worth mentioning. Through rather tortured reasoning, the law exempts as a conversion practice the occurrence of apparent sexual orientation change during the gender identity transitioning process. Using the example of a trans man who is attracted to women who could be considered as having changed his sexual orientation from lesbian to straight, Ashley (2019a) argues,

> However, under the hypothetical scenario, the sexual orientation did not change in the relevant sense. Since sexual orientation is based on gender identity and gender identity precedes transition, his sexual orientation did not change despite a nominal change in gender labels. While sexual orientation may change during or after transition, the purpose of transition is to affirm and support the person's gender, not to change their sexual orientation. (pp. 29–30)

It certainly is an open question as to whether the disgruntled consumer of social and/or medical transitioning would be so nuanced in their conceptualization were they to see an avenue to both punishing their providers and obtaining a hefty payday for their troubles. Such unintended consequences deriving from this law seem inherently plausible.

Ashley notes that many trans persons oppose mandatory psychological or medical assessments and diagnoses because they dehumanize and psychopathologize people. However, in a move of expediency over principle, the author acknowledges such assessments could constitute conversion practices but concedes including such language in the law ". . . could severely impede access to healthcare in trans communities" (p. 30).

It is also clear the language of the law allows identity development only if it does not include therapy-assisted fluidity or change.

> The requirement that acceptance and support be non-judgmental—without preference of targeted characteristic—indicates that foreclosing future identity development may

> nevertheless fall under the umbrella of conversion practices. Suggesting that one is accepted and supported as is but would not be accepted or supported if their targeted characteristics were different (e.g., "I accept you as long as you're straight.") would not fall under the notion of acceptance and support since it would be judgmental. (pp. 31–32)

The law appears to "foreclose" on future identity development of the client who says to his or her counselor, "I've experienced some shifting in my same-sex sexual attractions in the past and want to see if therapy can aid me now in the process of reducing those attractions and strengthening my heterosexual feelings and identity." In other words, to such a request the counselor can only respond, "Under law, I accept you as you are, as long as you don't try become less gay."

Such an understanding is fortified later when Ashley indicates the integration of religious and sexual identities is only accomplished if the individual deems their same-sex attractions and behavior to be on a par with their religious commitments.

> Conversion practices have justified the repression and discouragement of targeted characteristics via the goal of reducing the tension between the person's religious commitments and these characteristics. Those practices, however, place religious commitment above the targeted characteristics in the hierarchy instead of attempting to make them compatible for the individual. As such, it is not truly aiming at the development of an integrated personal identity. In this context as everywhere else, practitioners must always consider target characteristics "to be absolutely as valid and legitimate an outcome as any other identity or practice." . . . Development of an integrated personal identity is predicated in retaining both the religious commitment and the targeted characteristic of a person, and bring them into harmony." (pp. 34–35)

Beyond suffering from the erroneous view that the therapist is determining the pursuit and focus of SAFE-T, this perspective races past sensible caution to ensure informed consent and client-self-determination to prohibit clients from *ever* prioritizing their religious commitments above their same-sex attractions and behavior in a therapy or counseling setting. Again, this language appears destined to create unending conflicts for therapists, religious leaders, and non-LGB-identified sexual minorities within traditional faith communities.

Conclusion

This critique has provided a critical examination of three recent empirical studies purporting to show evidence of harms from exposure to change-allowing therapies. Thirteen areas of methodological and definitional concern have been presented to highlight the severely problematic nature of utilizing this research to support legal bans on SAFE-T in particular and contemporary change-allowing therapies generally. This analysis also briefly examined a model law for banning change-related practices, which identified some new developments in this ban template with particular relevance to faith-based practitioners and organizations. Overall, these articles shed more light on the motives and aims of the authors' agendas than they provide scientifically based assistance in unambiguously identifying

specific sources of harm attributable to contemporary SAFE-T. Hence, these studies (like most before them) cannot be credibly employed to support the draconian infringements on professional and religious speech and practice being dictated by current legislative bans.

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A Review of *The Madness of Crowds: Gender, Race and Identity* (2019)

by Douglas Murray[1]

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In the 1960s Mao Tse-tung promoted the mantra that "The Four Olds"—Old Customs, Old Culture, Old Habits, and Old Ideas—were to be rooted out of society and destroyed.

Douglas Murray identifies a more precisely focused set of four "Olds"—Gay, Women, Race, and Trans—and takes a very different view from Mao: that, imperfectly as these issues may have been dealt with in the past, their wholesale re-reworking today is the height of folly—"a great crowd derangement." Murray argues that the western world is in the process of throwing out a great deal that is considered bad without realising that what is brought in to replace it may be far from good. He uses three analytical categories in ordering his material: social justice, identity politics, and intersectionality. For instance, he highlights the absurdity that in identity politics a person's opinion may be deemed to be of greater value because they have certain minority characteristics such as skin colour or sexuality. When these characteristics intersect with each other, there is yet more opportunity for absurdity, as when an Irish senator claimed that the IRA hunger strikers in 1981 were striking for gay rights.

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Having outlined the broad contours of the minefield, Murray introduces the concept of tripwires, which may cause the unwary to take an ill-advised (politically incorrect) step with serious consequences.

He gives example after example of the herd mentality: unthinkingly following leaders whose positions are usually ill thought-out (and often Marxist). Moreover, when the declared objectives have been achieved (the battle almost won), these leaders seem to want to intensify the fighting when a more rational mind would tell them that the time had come to cease hostilities.

Gay

The first tripwire Murray identifies is "anything to do with homosexuality." The historic injustice against gays had been overcome by the end of the twentieth century, but instead of stopping the battle, activists added multiple letters to LGB, and then "something ugly happened." Everyone (including Stonewall) had been opposed to same-sex marriage, but now it became a foundational tenet. Although the train had almost reached its stated destination, it suddenly picked up speed and "went crashing down the tracks and into the distance." Examples include the American Psychological Association feeling the need "to advise its members on how to train 'traditional masculinity' out of boys" and an article about cycling deaths in London entitled "Roads Designed by Men Are Killing Women."

Murray is gay and does not support change-allowing therapy. Nevertheless, he sympathetically describes the brutal media experience of Dr. Michael Davidson of Core Issues Trust, who works with people who voluntarily seek help to reduce unwanted same-sex attractions. Davidson was treated with unprofessional rudeness by Piers Morgan on live TV, being called "bigoted," "malevolent," and "dangerous," but remained composed throughout the interview.

Murray likewise criticises the behaviour of the gay activists who forced Core Issues Trust to move the London premiere of their documentary film *Voices of the Silenced* to a different location by putting pressure on the original theatre venue to cancel the event. "None of the press which had sought to silence *Voices of the Silenced* had shown that [Davidson was] forcing unwilling participants to submit to a regime of heterosexual conversion." Rather, these critics redefined words so that "voluntary" meant "forced" and "counselling" meant "persecution."

In western society there have been many screeching U-turns on matters relating to "gay." Nicky Morgan MP voted against same-sex marriage in 2013. Two years later (on a fast track to political promotion he could have added) she held that such a view was "not merely evidence of 'extremism' but fundamentally un-British." Hillary Clinton had made a similar about-turn in the USA. Having painted this background, Murray embarks on a commendably open and persistent search for the causes of "gay" in order to better understand its growing acceptance in western society.

What Causes Gay?—The Current APA View

Although the general public have largely been persuaded that people are "born gay," he notes that the American Psychological Association says, "There is no consensus among scientists for the exact reasons [for sexuality]. . . . Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation." So, nature plus nurture plus not much choice.

What Causes Gay?—2014 Royal College of Psychiatrists Statement

Murray comments (p. 25) that "In 2014 the Royal College of Psychiatrists in London issued a fascinating 'statement on sexual orientation.'" He is impressed by their view that "sexual orientation is determined by a combination of biological and postnatal environmental factors. . . . There is no

evidence to go beyond this and impute any kind of choice into the origins of sexual orientation." (This is in fact essentially the same as the APA nature-plus-nurture-plus-not-much-choice formula set out above. In anticipation of the discussion set out below, the reader should take note of the word *postnatal* as a vital key to applying this formula.)

What Causes Gay?—Royal College of Psychiatrists Previous Position 2007–2013

Murray is apparently unaware of the controversy that preceded the RCP's 2014 position. Just a year earlier, the Royal College had given the Church of England a very different account:

> It would appear that sexual orientation is biological in nature . . . there is no substantive evidence to support the suggestion that the nature of parenting or early childhood experiences play any role in the formation of a person's fundamental heterosexual or homosexual orientation.[3]

It is clear that a massive shift occurred in the RCP's position on the causation of sexual orientation from 2013 ("biological . . . no substantive evidence of childhood experiences") to 2014 (the importance of "postnatal environmental factors"). It is also clear that in 2013 the College had misinformed the Church that the causation was purely biological. It has never corrected that error, which also undoubtedly influenced the British parliament's decision to change the law to permit same-sex marriage.

What Caused the 2014 Change in RCP's View?

The pre-2014 RCP statement was written as a submission to a Church of England "Listening Process" on human sexuality in 2007. A remarkable sequence of events then occurred which embarrassed the RCP. The Church of England set up a second Working Group on Human Sexuality, which produced *The Pilling Report* in November 2013. RCP simply dusted off its flawed 2007 submission and re-submitted it, virtually unchanged, to this second Church committee.

In parallel with this, Core Issues Trust (CIT) wrote a critical analysis (published as a booklet, *Beyond Critique*) of the 2007 document and submitted this analysis to the committee. Thus, the Pilling group found itself in effect looking at the RCP's 2007 document side-by-side with CIT's criticisms of that document.

Of the many flaws in the RCP position highlighted by CIT, Pilling drew attention to two, as follows (indented text, headings, and paragraph numbers below are all written by Pilling):

> **Is homosexuality harmful or is harm the result of social prejudice?**
>
> **205**. The evidence indicates that there is a greater instance of mental and physical illness and substance abuse among homosexual people than among the population at large. Thus, a major study by researchers from Harvard Medical School in 2001 concluded that 'homosexual orientation . . . is associated with general elevation of risk for anxiety, mood and substance-use disorders and for suicidal thoughts and plans.' In addition, many gay men in particular have a tendency to engage in high risk sexual activity. However, there is disagreement about the reasons why this is the case.
>
> **206.** One view is that it is due to the discrimination that gay and lesbian people continue to face. Thus, the submission from the Royal College of Psychiatrists declares: There is now a large body of research evidence that indicates that being gay,

[3] https://reflectionsasia.wordpress.com/2008/01/03/royal-college-of-psychiatrists-submission-to-the-church-of-england%E2%80%99s-listening-exercise-on-human-sexuality/

lesbian or bisexual is compatible with normal mental health and social adjustment. However, the experiences of discrimination in society and possible rejection by friends, families, and others, such as employers, means that some LGB people experience a greater than expected prevalence of mental health and substance misuse problems.

207. On the other hand, the Core Issues Trust point out that the three scientific papers referred to by the Royal College of Psychiatrists at this point actually refuse to attribute the causation of mental health issues among gay and lesbian people to societal factors. For example, one paper cited states, "It may be that prejudice in society against gay men and lesbians leads to greater psychological distress . . . conversely, gay men and lesbians may have lifestyles that make them vulnerable to psychological disorder."

208. This would seem to indicate that a causative link between social prejudice and health issues among gay and lesbian people is neither proven nor ruled out by the evidence. But the alternative possibility that homosexual orientation and all it entails cuts against a fundamental, gender-based given of the human condition, thus causing distress is likewise neither proved nor ruled out by the available scientific evidence.

And secondly:

Is there an issue about the durability and stability of same sex relationships?

209. There seems to be general agreement that, while there are undoubtedly examples of long-term, stable and sexually faithful relationships, gay, lesbian and bisexual relationships have tended to be less long-lasting than heterosexual ones, less sexually exclusive and more promiscuous. A key subtext of Jeffrey John's book *Permanent, Faithful, Stable*, for example, is the need for the Church to support permanent, faithful and stable relationships among bisexual and gay people, in order to counter some of the tendencies within the bisexual and gay community as a whole.

210. There is disagreement about the cause of these tendencies. As with the issue of health problems among gay and lesbian people, one explanation is the lack of social support until recently. Thus, the submission from the Royal College of Psychiatrists suggests: A considerable amount of the instability in gay and lesbian partnerships arises from lack of support within society, the church or the family for such relationships.

211. However as the Core Issues submission points out, the very paper which the Royal College cites to support its position states: We do not know whether gay male, same sex relationships are less enduring because of something intrinsic to being male or a gay male, the gay male subculture that encourages multiple partners, or a failure of social recognition of their relationships. The 'social experiment' that civil unions provide will enable us to disentangle the health and social effects of this complex question.

A remarkable aspect of this discussion is that on these two issues Pilling accepted Core Issues Trust's argument that the Royal College had misrepresented the evidence in the scientific papers that it had chosen to cite. Yet Pilling failed to comment on the most extraordinary fact of all: that all four of these texts—the above two claims by RCP that problems with LGB mental health, and brevity of relationship were largely society's fault, and the two scientific papers they cited,

which did not support their case—were written by the same person, Professor Michael King. His scientific papers are highly professional, but his application of them to the "gay" debate involved misrepresenting them—that is, misrepresenting even his own scientific work—arguably for an ideological purpose.

CIT wrote to the president of RCP offering to work constructively with the College to produce a better position statement. They declined. RCP did take action covertly, however, by working with a representative from the National Institute for Health and Care Excellence (NICE) to craft a new statement which took significant account of the criticisms of CIT. The outcome was the 2014 statement. They did not publicise to CIT, the Church or the scientific community this major change; it is a nice irony, however, that this 2014 document so appreciated by Murray was shaped in part by Core Issues Trust.

Returning to the overall issue, we may make two important summary statements: (1) both **APA and RCP now support a model that affirms the importance of nurture as well as nature** in causing homosexuality (though RCP denied this causal relationship until 2014), and (2) **RCP have still not communicated to the Church of England the fact that they have twice misinformed the Church** (and, by extension, Parliament and the whole scientific world) by claiming that the cause of homosexuality is "biological" with no influence from environmental factors.

Murray's Hardware and Software Analogy

In his continuing search for causes of "gay," Murray helpfully introduces the analogy of "hardware" (which can't be changed), and "software" (which can). These categories map logically on to the nature/nurture/choice model that is universally recognised. Nature is hardware, nurture is software, and he has now discarded choice (except for mention of a few religious conservatives who try to "smuggle" it back in (p. 30). He notes that the increasingly prevailing opinion in western society today favours the unscientific "hardware-only" view—born that way. "What is certain," says Murray, "is that the question as to whether it is innate or a choice—hardware or software—has a profound effect on the sympathy which people are prepared to expend on the issue."

But *bang!*—he has stepped on a major tripwire. It is true that the assumption of innate causation profoundly affects the sympathy of people's response to gay. But nurture, not choice, is the logical candidate to play the role of software. Yet nurture has now been dropped from the model and replaced by choice. Choice is not a plausible cause of "gay," he says. "What child would want to be more of a target for bullies by being gay? . . . So the zeitgeist appears to have settled on the 'Born this way' theory. . . ." *Bang!* The zeitgeist has made the same mistake: If the cause is not choice, then it must be nature. Nurture has been airbrushed out once more.

Epigenetics

Murray touches briefly on epigenetics, understanding it to be a search "to locate a gene variation that may cause homosexuality." This seems to presume that epigenetics is about finding a "hardware" outcome, whereas in reality epigenetic influences are essentially software—they are caused by environmental factors and are in principle reversible.

Restoring Nurture to the Model

Murray is aware that his hardware/software discussion has been problematic; it involves "avoiding any glances at . . . the science" (p. 31). But he does not appear to have realised that the reason his exposition is unsatisfactory may be that it has lost contact with the true software—the "postnatal environmental factors" that shape sexuality during childhood—*as affirmed above by both APA and RCP*.

This issue is of crucial importance. If we restored nurture to its proper place in the

model, what would science say to us? It would say that the nurture aspect comes logically and chronologically *after* the nature aspect—the time frames are different. We are by definition *not* "born *gay*" because at birth we have not yet encountered the *postnatal* nurture factors which will shape our sexuality *over time*. We may perhaps be born with a predisposition (hardware) that is more than usually sensitive to the slings and arrows (software) often experienced in childhood; or some individuals may have particularly distressing childhood experiences (software) (of which there are many examples in life and in the literature). But that is not being born gay. So, *our model involves a sensitive predisposition at birth followed by some traumatic experience during childhood.*

Testing the Model

Our model should be capable of withstanding testing against a range of known facts: It would be consistent with a major national cohort study in Denmark by Frisch et al., which said, "Our study provides population-based evidence that childhood family experiences are important determinants of heterosexual and homosexual marriage decisions in adulthood."

So, nurture/software is an important determinant of sexuality. It would be consistent too with the highly regarded findings of E. H. Laumann et al., based on the U.S. National Health and Social Life Study (1994) that "a pattern of homosexuality similar to those of biologically-based traits such as left-handedness or intelligence is exactly what we do not find" (p. 307). So, *not* hardware/ born that way. And (with reference to male homosexuality) the theory that "the environment in which people grow up affects their sexuality in very basic ways" is "exactly one way to read many of the patterns that we have found" (p. 309). Software again. The model also supports the findings of a thirty-year study by Wilson and Widom (2010) that men with histories of childhood sexual abuse were 6.75 times as likely as controls to report same-sex sexual partners.

Not least, the model is compatible with the findings from studies of identical twins. Murray states that the sexuality of male twins "interestingly appears to be identical when they are." This would suggest "born gay"—though he doesn't make this connection. But, uncharacteristically, he has made a category error here. The very opposite is the case: almost nine times out of ten, if one of a pair of identical male twins is gay, the other is not. Their sexuality is influenced mostly not by their shared nature but by their partly shared nurture. Finally, the software/nurture paradigm is compatible with the discipline of epigenetics as noted above.

In Murray's discussion of nature, nurture, and choice, the neglected middle child has been nurture. It is evident that, having introduced the concepts of hardware and software, Murray's discussion has been inconclusive, probably as a result of his initially defining software as nurture but then identifying it with choice. A most exciting project would be for him to revise his narrative in the light of the above observations, exploring in depth the "complex role" rightly identified by the APA for nurture, and its "postnatal" character as stated by the RCP, but neglected in the field of research and largely omitted from his own discussion.

Philosophical Considerations

Murray comments that Aristotle's apparent view that homosexuality arises in some people from birth and others from "habituation" is close to the positions of APA and RCP, but he says, "The only point of difference is that a reputable twenty-first century source would be unlikely to define "habituation" as "such as in those who have been abused from childhood." But Aristotle may have been nearer the mark than Murray realises. Laumann (p. 345) found that both men and women who had been "touched sexually" in childhood were almost four times as likely as the general population to identify as homosexual or bisexual. This is

further evidence of the influence of nurture factors in shaping the development of sexuality.

Murray reflects on "gays" (who want to be treated equally with others) and "queers" who want to be allowed to write their own rules (e.g., rejecting monogamy). He notes the incongruity of Tom Daley and Dustin Lance Black "having a baby" as if it were the most natural thing in the world, and touches on conflicting views within the gay "community" on a number of issues. Shortly after the Pulse nightclub massacre, a banner leading a gay pride parade in New York proclaimed that "Republican Hate Kills," forgetting that the Pulse perpetrator was a supporter of ISIS, not the Republican party. Intersections may sometimes be totally irrational.

Murray gives a brief and entertaining outline of the Marxist foundations that have led to the "gobbledegook make-believe masquerading as science." "After critical race theory and gender studies had done their work, was it not hard to explain why some things that seemed fixed (especially sex and race) were in fact social constructs whereas other things that may have seemed more fluid (not least sexuality) had become viewed as completely fixed? (p. 58). Fluidity of sexuality is a theme that he does not pursue further, unfortunately.

Women

The second of Murray's four main themes is women. It consists largely of illustrating the absurdities that arise when the traditional categories of masculine and feminine are abandoned. Societal "self-delusion over biological reality" is leading us "to reorder our societies not in line with facts we know from science but based on political falsehoods pushed by activists in the social sciences." Sex has been exploited in the media, especially Hollywood. The very phrase "the casting couch" says much.

So, what happens when women's rights meet Hollywood realities? Among several examples Murray describes is Jane Fonda being interviewed in 2007 on a show hosted by Stephen Colbert. At 69 Fonda was clearly keen to demonstrate to audiences that she still "had it." And so, during the interview she made a show of sexually stalking her host, enthusiastically whooped up by the audience. Murray devotes several pages to similar examples to illustrate the sexual degradation to which Hollywood had sunk by the early twenty-first century.

But "all this changed in 2017 with the first *Me Too* claims against Harvey Weinstein. At that stage there seemed to be a rapid consensus that any and all sexual advances against other people were intolerable. The new lines seemed to have been dug very deep as well as very fast." Suddenly a double standard had been revealed. A new morality had been established, but it had no agreed rules. So, Jordan Peterson suggested, "Here's a rule. How about no makeup in the workplace?" What was the purpose of makeup if not to make a person more sexually attractive? This was like red rags to a bull, and the media went into overdrive, accusing Peterson of saying that women were responsible for their own sexual assaults by virtue of wearing lipstick. Murray has no difficulty in showing how much hypocrisy underlies Hollywood's sexual reality compared with its self-proclaimed high values.

In business circles too, he gives examples where on the one hand, "equality" of women is preached, but, on the other, opportunities to claim the *superiority* of women are grasped when they present themselves. Christine Lagarde wrote, reflecting on the 2008 financial crash, "if it had been Lehman Sisters rather than Lehman Brothers, the world might look a lot different today."

One example of following an unscientific fad is what is known as "unconscious bias training," which is intended to ensure that minority groups get a fair chance of being recruited and promoted in employment. The most widely used instrument for this is the Harvard Implicit Association Test, which purports to enable people to identify who they may subconsciously regard as being in

an "in group" or an "out group." Murray asks with some irony whether if they find no such bias this is a failure or a success. He also gives an example of a friend of his who was asked if they would mind being given a pay rise in order to assist their employer in balancing the books as regards payment of minority groups.

A useful section deals with feminism, focusing particularly on some of the most popular feminist writers in recent times and making it clear that their thinking leaves much to be desired. Marilyn French claims that there is evidence that for about 3.5 million years the human species treated men and women equally. Then, about 6,000 years ago men began constructing "the Patriarchy," and for women it has "been downhill ever since." During the last 400 years things have got completely out of control, with men "mainly in the west" attempting to "tighten their control of nature and those associated with nature—people of color and women." Men are mounting "a global war against women." Women are rejecting this "toxic masculinity" and are demanding to be treated as "human beings with rights," including "that men not feel free to beat, rape, mutilate and kill them." This is the historical narrative taught by one leading feminist. Let the reader decide how closely it relates to their own experience.

In January 2019 this strong feminist thinking found its way into the official teaching of the American Psychological Association which claimed that 40 years of research showed that "traditional masculinity—marked by stoicism, competitiveness, domination and aggression, is undermining men's well-being. Not only is there no equivalent toxic feminism"; there is no way that these characteristics of manhood could be sensibly harmonised in a way that would be useful for daily life.

Murray asks (if indeed competitiveness is a male trait), "When is that competitiveness toxic or harmful, and when is it useful? Might a male athlete be allowed to use his competitive instincts on the racetrack? If so, how can he be helped to ensure that off the track he is as docile as possible?" (p. 103). (And, this reviewer would ask, is that docility always desirable in daily life—for example, if he and his girlfriend were attacked while walking down a dark street at night?) With these and other examples (soldier, firefighter, etc.) Murray exposes the farcical consequences of the direction in which the APA is going.

Finally, Murray prepares the ground for the chapter on trans, which will come at the end of the book. He returns to his analogy of hardware and software, saying that historically the differences between male and female were seen as a matter of hardware. Now it is being said that they are a matter of software—a person can change from one to the other. We are being not just asked, but expected, to radically alter our lives and societies on the basis of claims that our instincts tell us can't possibly be true.

Silicon Valley Is Not Morally Neutral

Before moving on to his next main theme, Murray gives a brief overview of the practical out workings of some of these intersecting principles in Silicon Valley. It is frightening.

For instance, for all its preaching, Google has only 2% of African Americans in its workforce. And Asians make up 35%, compared with only 5% in the U.S. population. There is an issue here which has not been addressed by the politically correct establishment (nor by Murray): Is it the case that people from all racial groups in the world are equally equipped in terms of the qualities that should enable an employee in modern society to advance their career through promotion on grounds of merit?

But while the Googles of this world make attempts to ensure that their employee practices are fair, something deeply troubling is going on. Based on the assumption that inequality of outcome is caused by discriminatory attitudes, attempts are being made to develop an approach called Machine Learning Fairness. Machines, surely, will not engage in

discrimination? Murray explores this by means of computer searches—for example, asking the machine for pictures of "straight white couples" results in outcomes where couples are neither straight nor white. The machine has been programmed against "straight" and "white" because these are categories that are out of favour. The potential consequences of this kind of reverse apartheid are very sinister indeed.

Race

On the question of race, Murray finds many similarities to the women and gay issues he has discussed. And many of the approaches to it equally incoherent. Universities have courses on "Black Studies," which celebrate "blackness." When it comes to "Whiteness Studies," however, the emphasis in one authoritative definition is on "problematizing whiteness." By a strange irony, the noble speech of Martin Luther King Jr. in 1963—that people should be judged by their character and not their skin colour—is reversed, and skin colour is everything.

For example, a decades-long tradition in a college in Olympia, Washington, was a one-day absence of non-white students from class to celebrate their identity. In 2017, however, the organisers flipped the arrangement, asking that all white people should stay away for the day. One lecturer objected, pointing out the difference between voluntary absence by oneself and absence enforced on others. He was verbally attacked, with students shouting obscenities and "Hey ho, hey ho, these racist teachers have got to go." The lecturer was humiliated, being made to move his hands in certain ways as though he were a puppet. A riot ensued, with the police being called. A few months later the lecturer and his wife (who taught in the same college) resigned.

On another occasion, at Rutgers University, a Black lecturer asked a Black student heckler, "Do facts matter?" His response was, "I don't need no facts." Murray suggests that this is an indicator of a deeper malaise in "Black politics," which argues that since Western society embodies some bad things, every element of it must be bad and must be replaced.

In another college, some Black students wrote a letter arguing for the banning of a speaker who had conservative views. They argued that the idea that there is a single Truth is a construct of the Euro-West, which regards Black and brown people as subhuman. Murray observes that the worrying thing is not that young people hold such views, but that they have been taught them. He is concerned that the belief that racism exists where in fact it does not, can easily spread from the universities to society, and "the ability to say racist things in pursuit of an alleged anti-racism has become utterly normalized."

An example of such absurdity is the casting of actors for the science fiction film *Altered Carbon*. An Asian man, Takeshi, dies and almost 400 years in the future is reborn into a different body, played by a different, Swedish-born actor. In the real world of our day this sparks a controversy—why did they not choose an Asian actor? According to *Time* magazine it was wrong to cast a "white guy" in the role. *Time* had forgotten that this was Sci-Fi, with the character being given a different body, or "sleeve." In any case it seems absurd (to this reviewer) that the demand should be for an Asian actor. If Takeshi was a Japanese character, it would be inappropriate to make his new persona Indian, for example, even though both ethnicities were equally Asian. Those intersections again.

Murray's major point here is that yesterday it wasn't like this. Actors and singers of all ethnicities were accepted in theatres, cinemas, and concert halls in the twenty-first century. Yet in 2018 when the BBC announced that Broadway star Sierra Boggess would take the role of Maria in the music of *West Side Story*, there was "denunciation on social media." She would be a Caucasian displacing a Latina in one of the few roles "open to" the latter. Boggess stepped down with a grovelling apology,

saying that to do otherwise would be "a huge mistake." Murray comments, "A talented star had been bullied into submission. And in the name of "progress" and "diversity" the most regressive and undiverse thing imaginable clocked up another victory" (p. 143). He points out ironically that the same logic could be used to reserve some roles for white people. "Casting can either be colour-blind or colour-obsessed, but it probably cannot be both" (p. 144).

Sharing of the good things between cultures could be very beneficial, but "sadly" a theory got there first—"cultural appropriation"—making it "not OK." Portland, Oregon, is described as having turned from being a "foodie paradise" because of the variety of its restaurants, to "a foodie warzone." People with the wrong DNA are considered to have no right to cook ethnic food.

Publishing houses now use sexual and racial quota systems rather than merit in deciding what books to publish. And politics can trump ethnicity. Black commentator Michael Eric Dyson said, "I bet a lot more Black people would support Rachel Dolezal than would support, say, Clarence Thomas."

Peter Thiel, a gay man, and Black actor Kanya West both declared their support for Donald Trump and then found themselves disowned by those communities. This "suggests that 'Black'—like gay—is in fact a political ideology." So, Whoopi Goldberg could say of Rachel Dolazel, "If she wants to be Black, she can be Black." Murray remarks that the implication of this is that "a Caucasian wearing bronzer but holding the 'right' opinions was more Black than a Black Supreme Court Justice [who] happens to be a conservative" (p. 156).

He gives multiple examples of people being punished for using language that is considered inappropriate—but only if used by white people. But he adds that "Asian privilege is currently being weighed up in the social justice scales" (p. 162).

In 2014 a group of Asian students gave evidence that their university's admission process routinely downgraded Asians under such vague factors as "likeability," even though the students had never even been interviewed.

Murray gives an interesting account of the controversy caused by publication of The Bell Curve, which posits different IQ averages for people of different ethnicities, with Asian-Americans and Ashkenazi Jews at the top. Neuroscientist Sam Harris admits having avoided contact with the authors, such was the vitriol of the debate. This does not bode well for the future, and Murray closes the chapter by saying that "people who jump up and down on this quietly ticking ground can have no idea what lies beneath them."

Trans

Murray comments that every generation does some things that to us looking back are "morally stupefying," such as the slave trade and using children to clean factory chimneys. What may be in that category for our time? He gives the example of Nathan Verhelst, born a girl and named Nancy. She had a grotesque upbringing. When she died, her mother said, "When I saw Nancy for the first time, my dream was shattered. She was so ugly . . . we never had a bond." In her thirties she had three sex-change operations, seeking peace of mind. But they did not work: "When I looked in the mirror I was disgusted with myself." So Nathan was euthanized by the state. Murray imagines a future person looking back saying, "So the Belgian health service tried to turn a woman into a man, failed and then killed her?"

Murray ponders the fundamental questions. What is trans? What makes someone trans? He notes that trans has become a "dogma" much quicker than gay, along with a demand to "make up the science around it." Campaigns to permit alteration of birth certificate to change people's sex at birth. Children taught that boys can have periods. "Crowd madness." Stonewall have a new t-shirt saying, 'Some people are trans. Get over it.' But are they? And should they? asks Murray.

He seeks to start from the known before venturing into the unknown. The phenomenon of intersex is a scientific fact—in his terminology, hardware. He appears to side with those who prefer caution rather than early major surgery. Transsexualism is in another category. He sympathetically describes the experiences of James Morris. An army veteran from WWII, he became a successful journalist, happily married with five children. Murray describes Morris's experience of surgery in some of Morris's own words, including the retrospective comment, "I would take a knife and do it myself [if no surgeon were available]." Murray ponders the ethics of all this, observing that there is a big problem in "how to navigate the leap from biology to testimony." He sets out the diagnostic dilemma: If someone thought they were Lord Nelson and wanted an arm removed, could they be sane? And if not, what about a man wanting his penis cut off?

And though science has found no hardware reason why people want to change sex, "there is still a push—as with homosexuality—to move the issue from software to hardware" (p. 199). Activists had for years been trying to de-pathologize trans, when J. Michael Bailey stood "on top of the landmine" and faced deep opprobrium for advancing new opinions regarding causation.

Continuing his quest for causation, Murray comments that a man wanting to have his penis cut off could hardly be said to be making a "choice." "Yet even this does not 'prove' that trans is a hardware issue," he says. (Once more, he omits the possibility that nurture plays a software role in causation.) He muses that some people believe that trans is the new gay and fear being caught on the wrong side of history, "and in some sense the similarity is there. If there is nothing genetically different about gay people, then the only thing that signifies a difference is their behaviour. Gay people "are gay when they say they are and when they do the things that show people to be gay." But once again Murray omits the possible influence of nurture. What if the gay (or the trans) person is a young man who was sexually molested as a child, and his gayness, though not genetic, is not just "being gay when you say you are" but a daily experience of sexual desires whose origin lies in that early painful nurture?

Murray briefly discusses one fundamental difference between gay and trans—the irreversibility of the latter post-operatively. He is disturbed about the "cluster effect" of trans sweeping through schools and urges that questions about the age at which drugs and surgery are permitted are "worth contesting deeply." Many who identify as gender dysphoric in childhood will grow out of it, "many of them to become gay." This last observation suggests that trans may be the next stop after gay on the nurture/software train journey—a question surely meriting further research.

A case study supports this argument. James is a "very gay" man who thinks he may be trans. He progresses far down the road towards surgery but pulls back at the last minute. He says he is very glad he did. He wonders why suicide rates don't change between pre- and post-operative trans people. He feels he was put on an NHS conveyor belt towards surgical transition. "He was never offered any counselling" (of the type offered by Mike Davidson). It was very easy to get the drugs he wanted.

Murray comments that gay groups have generally supported trans rights as being part of their continuum but observes that many trans rights claims "profoundly undermine" the claims of the gay movement. "Some people are gay. Or possibly trans. Or the other way round. Get over it." He gives an anecdote of a young woman student at Hillary Clinton's alma mater, who decided to identify as a "masculine of centre gender queer person," with amusing contradictory consequences not narrated here.

The Feminist Tripwire

There is inevitably a tripwire between trans and feminism. This makes sense, says Murray, because feminists who have stoutly defended their identity as a matter of

hardware (fixed) can hardly accept the proposition that it is actually software and they could change. He recounts the experiences of feminists such as Julie Bindel, Julie Birchill, and Germaine Greer.

There is a particular poignancy in the well-known experience of Greer. Murray says that "insulting Greer, and indeed excommunicating her from the latest version of feminism became a rite of passage for a generation of women which had—whether they knew it or not—benefited from her trailblazing" (p. 215). In *Varsity* magazine, at Cambridge University (Greer's own alma mater in the 1960s) Eve Hodgson wrote an article headlined "Germaine Greer can no longer be called a feminist." According to its author, "Greer is now just an old, white woman who has forced herself into exile. Her comments are irreparably damaging, reflecting a total lack of regard for trans lives. Thinking what she thinks, she cannot be a prominent feminist any longer. She no longer stands for the same things we do" (p. 215).

Trans and Children

Murray is concerned that children are so easily caught up in the idea of trans that it can spread without any justification, particularly in schools. In one example from the north of England, a 16-year-old girl told her parents first that she was gay . . . and then trans. When they attended a Parents' Day they discovered that the school was already using a boy's name and pronouns in dealing with their daughter.

A Scottish government document suggests that children should be able to compete in sports in the gender that they feel most comfortable in, and that parents should not be informed if their child wants to share a room with members of the opposite sex on school trips. All this, Murray remarks, in schools which have to get parental permission before issuing an aspirin to a pupil.

The internet abounds with people trying to push drugs and trans practices. Some of these people have become celebrities, with TV updates as to how their transitioning is going. Murray refers to "a slide of acceptance which led the NHS in England to sign an agreement that NHS professionals 'will never suppress an individual's expression of gender identity.'" "The assumptions all continue to go in just one direction," says Murray. And many parents, especially in the U.S., are told by doctors that if they prevent their child from transitioning, the result will be suicide. He gives an example of supposed research into puberty blockers for children (not repeated here), which he says requires "a strong stomach" to read.

Murray considers that the current "stampede" into trans may lead to "an avalanche of lawsuits." Perhaps, indeed, it will require the forensic spotlight of the courtroom to bring people to their senses.

Conclusion

Murray summarises his argument by saying that the activists who want to radically change society believe that the various "oppressions" he has discussed are interlocking, and if we can unweave them we shall be able to achieve social justice. "After which something will happen. Precisely what that thing is remains unclear. But in reality "the interlocking oppressions do not all lock neatly together" like a Rubik's cube. He is concerned that the "dogmatic, vengeful liberalism" of our day risks "undermining and even bringing down the whole liberal era."

Gay is not "the new Black." There is a complete disconnect between "gay marriage" and anti-miscegenation laws. One writer in a feminist journal suggested that Rachel Dolezal should be allowed to change race just as Bruce Jenner was allowed to change gender. But the argument that had worked for gender didn't work for race, and the directors of the journal were forced to resign.

An 18-year-old Texan girl taking testosterone in order to transition to male won a wrestling competition. Normally such

drug-taking would lead to disqualification, but in this case that rule has to be set aside. "As always, it gets worse," says Murray.

What is really going on?

There are contradictions everywhere in what Murray refers to as "this new religion of social justice." But it would be wrong to imagine that they can be harmoniously resolved by constructive discussion, because the activists are working with a Marxist objective: "If you cannot rule a society . . . then you can do something else . . . you sow doubt, division, animosity and fear . . . And then present yourself as having the answers . . . the details of which will follow in the post" (p. 254).

One suggested response to such a person is to ask, "Compared to what?" Where in the world today, or in the past, should we look to see an example where the other party's complaints have been addressed? Murray urges that we incline towards generosity. He also encourages face-to-face interaction, noting how in the 1830s Alexis de Tocqueville was impressed by the significance of assembly in the United States. Face-to-face meetings of the citizenry allowed them to resolve problems often before any other authority was needed. He then immediately puts this theory into practice with respect to his differences with Michael Davidson, flagged up in his opening chapter:

> I do not especially like [Dr.] Michael Davidson's ideas about being gay, but if I decided that he and his 'Voices of the Silenced' should be viewed only in the most negative possible light then I would not merely have no need to listen to him. I would not want to live in the same society as him. Yet we do live in the same society, and we have to find some way to get along together. It is the only option we have because otherwise, if we have come to the conclusion that talking and listening respectfully are futile, the only tool left for us is violence. (p. 254)

Reviewer's Postscript

As a supporter of Mike Davidson's work, this reviewer is surprised and delighted at Douglas Murray's openness to talk to him. I believe that they have much in common, not least the spirit of generosity shown here by Murray. Mike has much to say that I believe will be of great interest to Douglas as a conversation partner. In particular, the identity of nurture as the elusive middle child may enable Douglas to reappraise his discussion of gay in a way that could be of real benefit to gay people, to science and to society.

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A Review of Abigail Shrier's *Irreversible Damage: The Transgender Craze Seducing Our Daughters*

By Abigail Shrier[1]

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Irreversible Damage: The Transgender Craze Seducing Our Daughters by Abigail Shrier is an important resource for mental health professionals who practice truthfully and operate in the best interests of their patients. Shrier, a freelance contributor to the *Wall Street Journal* as an opinion writer, took on the role of an investigative journalist to compose this timely, controversial, and evidenced-based treatise on the transgender phenomenon impacting adolescent girls. Shrier writes with a sense of urgency to garner attention to a growing trend with adolescent girls overlooked by the general society, medical professionals, and mental health providers.

The introduction to the book, appropriately entitled *The Contagion*, contains a rich, data-supported defense for the book. A study by de Graff et al. (2018), which reports a dramatic increase in biological female adolescents in the U.K.

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seeking gender reassignment, is cited by Shrier as foundational for writing *Irreversible Damage*. In the study by de Graff et al., an increase of social media usage and a higher level of psychopathology was found among adolescent girls seeking treatment for gender identity incongruence—a fact that is documented throughout the book. The de Graff et al. study prompted Shrier to investigate similar data in the U.S., only to find similar evidence of a dramatic increase of transgender identification among American teenage girls. Shrier presents her book as a much-needed message for all Americans. She states:

> Whether or not you have an adolescent daughter, whether or not your child has fallen for this transgender craze, America has become fertile ground for this mass enthusiasm for reasons that have everything to do with our cultural frailty: parents are undermined; experts are over-relied upon; dissenters in science and medicine are intimidated: free speech truckles under renewed attack; government healthcare laws harbor hidden consequences; and an intersectional era has arisen in which the desire to escape a dominant identity encourages individuals to take cover in victim groups. (p. xxiii)

I. The Evolution of Transgender Identification Prevalence Among Adolescent Girls

In Chapter 1, *The Girls*, Shrier gives us a glimpse into the lives of emotionally fragile teenage girls who, due to a lack of in-person social interactions, regularly seek guidance from social media to inform their thoughts about their gender identity. Shrier includes content from her interviews with parents of transgender-identifying, biological girls. In describing the account of "Julie," Shirer provides details of her upbringing collected from Julie's lesbian mothers, who reported no symptoms of gender dysphoria during her childhood. Shrier discovered that Julie was an active member of her school's Gay-Straight Alliance, with multiple members of that group identifying as "trans." Shrier gives two other examples of girls that, according to their progressive parents, did not display any symptoms of gender dysphoria during childhood or puberty, but seemed to suddenly identify as "trans" during adolescence.

In Chapter 2, entitled *The Puzzle,* Shrier addresses the damaging consequences of promoting transitions for biological female adolescents, through medication and surgeries, without exploring the underlying mental health symptoms that most of these girls also experience. Shrier enlists the help of Dr. Lisa Littman, a reproductive health specialist and medical researcher. Dr. Littman was alarmed by the surgical statistics report of American Society of Plastic Surgeons (2017) showing that gender transition surgeries for natal females quadrupled between 2016–2017. The issue once attributed mostly to boys, and considered rare (less than 1 in 10,000) in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5, 2013), was now shifting to girls in profoundly large numbers.

Dr. Littman (2018) conducted a study of 256 parent reports of their transgender-identified daughters. Three things were discovered from the parents' reports about their daughters: 1) no signs were present during early childhood of gender dysphoria; 2) 65 percent of parents said their daughters came out suddenly as transgender after prolonged social media exposure; and, 3) most of the girls had exposure to another transgender individual within a close friend group. Shrier indicates that Dr. Littman

developed a new name for this type of gender dysphoria expression: rapid-onset gender dysphoria (ROGD). Dr. Littman classified ROGD, which is not an official diagnosis, as a type of peer contagion, and feared that young girls were not getting the treatment they needed by mental health and medical professionals.

Dr. Littman's (2018) research published in *PLoS One* was wrongly discredited as having conservative bias; however, the parents interviewed in Littman's study were predominately supportive of gay rights, politically progressive, and white. Shrier documents how Littman suffered attacks from LGBTQ activists and was continually ostracized by her peers, who called her names like "bigot" or "bully." Even though she recorded her professional observations using the same methods for assessing childhood mental health in existing research, Littman lost her job just for publishing and defending her findings.

II. The Influence of Social Media, Educators, Parents, and Mental Health Professionals

Shrier devotes Chapters 3 through 6 to sectors of American society promoting the false narrative that biological gender assignment can be altered to fit how a person feels. Shrier identifies several social media celebrities, primarily on YouTube, that vulnerable adolescents listen to and obey as if they are members of a religious cult. These social media transgender cult leaders offer advice on how to self-diagnosis your gender identity (e.g., if you are questioning whether you might be "trans," then you are "trans"). Adolescent girls can also find YouTube instruction videos on how to secretly obtain and wear breast binders, properly use testosterone (without revealing any of the dangers and downplaying irreversible side-effects), and effectively deceive parents and doctors to get a gender dysphoria diagnosis, meds, and treatment. Some YouTube celebrities promised followers they will be a "glitter family" for them if they are rejected by their biological families. "Like glitter, they add fun adornment without the weight or encumbrance of an actual relationship" (Shrier, p. 56).

In Chapter 4, *The Schools*, Shrier documents how the U.S. educational system is now a type of indoctrination program, comprised of politically correct propaganda and pro-sexual diversity curriculum. Depending on the state, some school systems assist students in obtaining the hormones they want without parental notification. According to Shrier's research and interviews, many educators believe parent education on sex is inadequate. They believe it is their responsibility as educators to normalize LGBTQ sexuality and gender diversity in the minds of the K–12 public school population for the sake of promoting inclusion and social justice. Shrier is quick to point out that the curriculum being utilized, including the book *I Am Jazz* (Herthel, 2014) that is read to kindergarten classes, is rooted in sexual identity politics and gender ideologies, not science. Activist groups like the ACLU, Planned Parenthood, and GLSEN are providing the curriculum, guest speakers, teacher training, and after school clubs (e.g., the Gay-Straight Alliance).

Shrier revisits telling real-life stories from parents in Chapter 5. Parents may not realize how they are promoting their child's gender confusion. Many parents contribute by default by adopting progressive worldviews, having minimal involvement with their adolescent children, or lacking adequate knowledge. When parents tried getting help for their troubled daughters, they were greatly disappointed to find what little help was available to them. One mother sought out "so-called therapy" at a gender clinic, but later learned it was really all about

guiding clients through gender transitioning steps, beginning with hormones and puberty blockers, without any form of psychotherapy.

Examples of how parents are now fighting back to help their daughters are addressed in Chapter 5. One mother's heartbreaking experience with her transgender-identified daughter led her to develop 4thWaveNow.com as an online resource blog for parents questioning the medicalization of transgender youth. Another mother founded the Kelsey Coalition (kelseycoalition.org) to help protect young people identifying as transgender from medical or psychological harm. Shrier claims that some mothers "have grown disillusioned with progressivism and disaffected from the Democratic Party, which they believe has abandoned girls for the sake of the transgender cause" (Shrier, p. 86). Unfortunately, these mothers are fighting a seemingly impossible-to-win battle against mainstream American culture.

III. Politics, Laws, and Activists: Challenges for Therapists Who Adhere to Biological Truth on Gender and Evidenced-Based Practice

The standard treatment for transgender patients is something called "affirmative care." The American Psychological Association (APA) provides guidelines for affirmative therapy that stipulate mental health professionals should adapt their views of gender to include transgender as normal rather than as pathological. Shrier believes the APA guidelines force therapists "to endorse a falsehood: not that a teenage girl feels more comfortable presenting as a boy—but that she actually is a boy" (p. 98). Shrier also questions one gender therapist, Dr. Randi Kaufman, who claims parents must use a transgender patient's new name and pronouns to provide necessary support. Dr. Kaufman also claims that since a transgender patient's mind cannot be changed, their body must be changed to align with their perceived gender identity. Of course, Shrier rightly points out that this is problematic for patients who identify as gender-fluid or non-binary because there is no standard for what gender fluid or non-binary persons looks like—the physical presentation is created in the mind of the patient based on how they feel.

Shirer issues a warning for therapists who do not adhere to the "affirmative care" mandates from the APA or laws within certain state governments. Therapists who reject the affirmative care model hold to a belief that biological gender cannot be changed, and that carving up an adolescent child's body upon request is a form of self-harm and malpractice. Shrier suggests that dissenting therapists keep quiet about their work or risk losing their licenses, especially if they practice in one of the states where "conversion therapy" for adolescents is illegal. Despite the risks, some therapists continue to hold firm to their beliefs and speak out, like Dr. Paul McHugh, who believes the transgender craze is being improperly treated and will result in "patients suing their doctors" (Shrier, p. 142). Examples of other therapists specializing in gender dysphoria are presented, all of whom believe that true gender dysphoria is a form psychopathology to be treated, and that practicing affirmative therapy "is either a terrible dereliction of duty or a political agenda disguised as help" (Shrier, p. 127). To date, no longterm studies exist that indicate gender dysphoria or suicide ideation decreases after receiving hormones or cross-sex transition surgery (see Hruz, 2019).

Another battle for dissenting mental health therapists to overcome is with LGBTQ activist groups. What makes this battle easier to overcome is that LGBTQ, social justice, and feminist activists have encountered impasses among themselves, leaving them to question just what is a "woman"? Better yet,

who gets to define what a woman is? Shrier points out that women athletes have become downgraded by male athletes competing as "trans" women. Shrier describes how the transgender movement has conflicted with lesbian feminists, who are fighting to preserve their identities as biological female lesbians. "In fact, gender ideology puts transgender individuals into direct conflict with radical feminists who believe sex is the defining feature of one's identity" (Shrier, p.150).

One of the most disturbing aspects of the "trans movement" is how it acts as an intersectional shield. In Dr. Littman's (2018) study, Shrier reiterates, over 90 percent of parents were white, the most reviled group on politically progressive campuses in the U.S. Identifying as "trans" allows girls to escape the dreaded straight, white, and rich demographic of their parents, and find an affirming community among their peers. Of course, the evidence indicates that trans ideology begins much earlier—in high school or even middle school. An adolescent girl Shrier interviewed informed her that transgender "is a high-status identity in high school, 'lesbian' is not" (p. 151). The implication is that the desire to be "cool," politically relevant, and accepted by peers, could potentially be the driving force for the transgender movement rather than true gender dysphoria.

IV. Final Thoughts

Additional chapters provide transition stories from families of transgender girls, details about failed surgical transitions of female to male adults, and one account of transgender regret post transitioning from female to male. Shrier even defines a "healthy" form of transgender identity—where an adult does not deny his biological gender but prefers presenting as the opposite gender. In other words, Shrier suggests, some transgender-identified adults do not suffer from gender dysphoria, nor do they experience any psychopathology. There are many references to transgender adults in the book who did not have positive transitioning experiences and experienced mental health issues as a result. Shrier also includes a chapter on girls who experienced regret and went through a painful process of de-transitioning. When describing the de-transitioning young women she interviewed, Shrier states that most "of them struggled with mental health and engaged in self-harm" (p. 202). The emotional and psychological issues they had before transitioning remained.

In the last chapter, *The Way Back*, Shrier offers advice from parents she interviewed on how to protect children from journeying down the path of gender confusion and self-harm. She advises parents based on research data, something that is often ignored by mental health or medical professionals. Although Shrier wrote the book about the transgender craze impacting adolescent girls, most of the advice is also applicable for boys, such as recommending parents keep children off social media and not buying them smartphones. Shrier has more freedom as a freelance journalist to offer advice to parents about the dangers of gender ideologies than a mental health professional or even a medical doctor in the politically correct and cancel-threat culture in which we currently live. For this reason, *Irreversible Damage* is a valuable resource for mental health professionals to read and utilize in their work with families of transgender identifying children.

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A Review of *Sexual Identity & Faith: Helping Clients Find Congruence* (2019)

By Mark A. Yarhouse[1]

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Mark Yarhouse is arguably the most influential Christian voice in the field of sexual orientation and gender identity. He is an accomplished scholar who has attempted with general success to bridge the sometimes cavernous divide between secular professional and Christian worldviews as pertains to sexual minorities. While most of his books have been addressed to a Christian lay audience, this is not the case with *Sexual Identity & Faith*. The intended audience for this work are licensed Christian and other conservatively religious practitioners and non-religious licensed therapists who work with religious populations. This book is an expanded follow-up to his initial 2006 paper

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(co-authored with Warren Throckmorton) outlining their Sexual Identity Therapy (SIT) framework for working with often conflicting sexual and religious identities of clients.

The Sexual Identity Therapy Framework

Positioning of SIT

Yarhouse positions SIT as a "third way" approach between sexual orientation change efforts (SOCE), which he generally dismisses, and gay-affirmative therapy (GAT) approaches, toward which he seems generally more sympathetic while clearly acknowledging potential limitations for Christian clients. He describes SIT as "client-affirmative" with a focus on sexual identity exploration that provides a nuanced understanding of both mainstream LGBTQ+ and religious communities (p. 7). As Yarhouse developed and practices SIT, it is primarily cognitive-behavioral, person-centered, and more recently narrative in its theoretical orientation. SIT has four primary phases: assessment and advanced consent, psychoeducation, attributional search for identity, and personal congruence. Yarhouse treats each of these phases in detail.

Assessment and Advanced Consent

SIT commences with a detailed assessment process focusing on both sexual and religious identities of the client, as well as the history of any conflict between these identities. Clinicians are encouraged to assess the clients' awareness, development, and any synthesis of same-sex sexuality. Furthermore, Yarhouse stresses the value of assessing a number of common milestones in clients' potential formation of their sexual identity, such as first disclosure of same-sex attractions (SSA), private adoption of a gay identity, and first engagement in same-sex behavior. Religious identity of clients must also be assessed, with an aim of obtaining a better sense of clients' religious faith as it relates to and informs their same-sex sexuality. Such assessment should include clients' motivations and expectations for pursuing therapy. Yarhouse also recommends, and wisely, I believe, that therapists conduct ongoing assessment of the therapy process. He provides an extensive Quality of Life instrument (pp. 32–36) he uses for periodic assessment with clients.

The SIT assessment phase also includes advanced informed consent: "Advanced informed consent should include discussion of what is causing the client's difficulties, professional treatment options and paraprofessional alternative, possible benefits and risks of treatment, and possible outcome without treatment" (p. 38). This discussion may include a statement about the APA's position on same-sex sexuality and theories of etiology for SSA. Regarding etiology, Yarhouse generally adopts the APA's stance, which indicates research does not support any one theory of sexual orientation development and that multiple factors are likely to converge and "provide a 'push' in the direction of same-sex sexuality" (p. 41). The range of possible treatment options are briefly outlined. Yarhouse correctly observes, "Some professionals provide GAT, which is itself not so much a protocol as a posture toward being gay" (p. 44). GAT typically has the goal of helping the client live openly and with integrity as a gay person. SOCE, according to Yarhouse, is an attempt to change clients' sexual orientation, and there is broad consensus that these practices are unethical and, for minors, now illegal in many states. As a result, SOCE currently is more likely to occur in faith-based ministries. Then Yarhouse adds (p. 44):

> It should be noted too that the primary potential benefit of SOCE approaches may be simply the opportunity for the

> client to explore their identity and find social support while learning adaptive coping in a context that honors their religious perspectives (APA, 2009). These benefits are precisely the emphasis of SIT and related "third way" approaches to clinical practices today.

The author concludes his discussion of advanced informed consent by acknowledging the difficulty some therapists will have with clients whose ultimate choices surrounding their identity conflict will lead them to a ". . . resolution that does not align with the clinician's own values. . . . How difficult will it be for you to present a range of options to clients without setting up one option as the one you prefer?" (p. 49).

Psychoeducation and Attributional Search

Yarhouse identifies two primary components of psychoeducation as the second stage of SIT. He discusses with clients his three-tier distinction between sexual attractions, sexual orientation, and gay identity. This is a very helpful differentiation about which Yarhouse goes into some detail (pp. 60–66). I would certainly concur in recommending all clinicians working in this area to be familiar with this distinction when providing psychoeducation to same-sex attracted clients. The other component of this stage is working with clients to have them "weigh" the relative importance they give to several parts of their experience. These parts include the strength of their same-sex sexuality, current and past sexual behavior, and personal beliefs and values.

The third SIT stage of attributional search for identity refers to ". . . how a person makes meaning of their experience of same-sex attraction" (p. 11). Yarhouse describes this middle stage as a cognitive search for meaning wherein clients are helped by the therapist to ". . . make sense of their same-sex sexuality and begin to develop a meaning-making structure that will help them thrive and achieve congruence" (p. 80). Two examples of milestone attributions are when clients initially attribute meaning to same-sex sexuality and when they assess the meaning of the word "gay" in relation to themselves. Here the therapist listens to the sense-making stories (i.e., attributions) that are embedded in how clients think about their sexuality and attempts to understand how they see their sexuality through interpretive lenses. Yarhouse identifies three such lenses through which clients may view LGBTQ+ issues: the diversity lens, the disability lens, and the sacred lens.

The author's discussion of these lenses is very useful to both clinician and client. In the diversity lens, persons with SSA are viewed as part of the LGBTQ+ community, and their sexuality should be recognized and celebrated. This is the lens of GAT. The disability lens assumes because SSA is not the normative sexual experience, it is ". . . either the result of something not functioning properly or evidence of sexuality not being as it should" (p. 85). Here same-sex orientation can be a variation in nature and not likely to change, but sexual impulses are not seen to justify engaging in same-sex sexual behavior. Finally, in the sacred lens clients view the same-sex sexuality as a variation occurring in nature and regard it with concern as it violates something sacred. They may see their sexuality as an indicator of spiritual deficiency, hence

> . . . whereas the disability lens treats same-sex attractions as an enduring reality . . . the sacred lens regards them as something that must be contended against, that must be healed. Requests for SOCE often

> come from adherents of the sacred lens, in my experience. (p. 47)

Yarhouse notes that therapists need not uncritically accept the lens clients have adopted and can explore with clients the benefits and drawbacks of each lens. However, he cautions, "Clinicians do not adjudicate among the underlying philosophical and theological views that undergird different lenses, but rather help our clients become more aware of how they are seeing their sexuality . . ." (p. 91).

In this stage Yarhouse also helps clients identify narratives that may have come to dominate and influence their lives. He describes two main scripts, one derived from traditional religious communities and the other from mainstream LGBTQ+ communities (pp. 94–102). The "Shame script" includes four tenets involving (1) SSA as a departure from who people are meant to be, (2) moral culpability not just for sexual behavior but also for experiencing SSA, (3) SSA signals a willful disobedience against God, and (4) centering life on Christ will free you from SSA. This is in contrast to the "Gay script," which Yarhouse characterizes as including (1) SSA is a categorical distinction between (LGB and heterosexual) types of people, (2) SSA signals your fundamental nature as a person, (3) sexual attractions are the core of your identity and sense of self, and (4) sexual behavior is morally permissible and an expression of identity and who you really are. Yarhouse rightly cautions that these scripts are not universal within either religious or LGBTQ+ communities and warns against stereotyping.

Personal Congruence

In the SIT approach, congruence is conceptualized as ". . . the bringing together of one's belief/values and one's behavior/identity" (p. 133). Preparatory to this congruence, clients may need to identify and remove the constraints that experiences and dominant narratives may have placed upon them that interfere with the goal of congruence. Yarhouse notes that the life stories of clients are often influenced by relationships and cultures in which they live, which can limit the way clients experience their life stories through "proscriptive" and "prescriptive" constraints. Within SIT, ". . . a proscriptive constraint places a limit on what a person can share, drawing a line between what is and is not allowed to be mentioned"; whereas a prescript constraint ". . . insists that certain questions be asked only in a prescribed manner and allows only for a prescribed conclusion" (p. 107). Although constraints can derive from both religious and mainstream LGBTQ+ communities, the SIT process is the same.

> [Clients] can then acknowledge the existence of the constraints and decide how they want to respond to them. They can consider the impact of adhering to the constraints placed on them and decide whether they wish to concede to a particular constraint or to reject it. If they choose to reject a constraint, they could use therapy to learn how to respectfully communicate that rejection and explore alternatives to the proscriptions or prescriptions being communicated. (p. 107)

In subsequent chapters, Yarhouse describes the technique of "interviewing the concern," assisting clients to identify the chapters in their lives, and the importance of working with clients to help them develop a counternarrative to the narrative that gave rise to their identity conflict. He observes Christian clients in particular as having problem narratives that usually involve a shame script and/or a gay script. Some

examples of these problem stories associated with a shame script and their suggested counternarratives include (p. 119):

> ● "My same-sex attractions are willful disobedience." [Counter-narrative: "My same-sex sexuality is not a result of willful disobedience; I found myself experiencing same-sex attraction when I was a teen. I have decisions to make about how I live my life and what my sexuality means to me, but to say it was a choice is simply not true."]
> ● "My same-sex sexuality is the result of bad parenting." [Counter-narrative: "I don't know why I experience same-sex attractions, but I don't think there was anything my parents did or didn't do that caused it".]
> ● "My same-sex sexuality is the result of sexual trauma." [Counter-narrative: "I'm sure sexual abuse complicated my sexuality, but I don't know that it caused me to experience same-sex attraction."]
> ● "To be gay is a sexual addiction." [Counternarrative: "To be gay is to experience same-sex attractions as an orientation—it is not an addiction."]
> ● "To be gay is an abomination." [Counternarrative: To be gay is not an abomination, but my same-sex sexuality raises questions for me about how I ought to live my life."].

From my perspective, these counternarratives are about reframing understandings and developing self-compassion through a more or less Christian values framework.

Developing such counternarratives helps SIT clients to reach the end goal of therapy, i.e., congruence. In SIT, "congruence is achieved when a person is able to adopt an identity outcome and live it out in ways that are keeping with their beliefs and values" (p. 12). Congruence can be achieved in two primary ways: (1) moving behavior and identity into alignment with previously held beliefs and values, or (2) realigning beliefs and values so that they become congruent with behavior and identity. The former is usually associated with maintaining traditional religious identity and sexual behavior, while the latter is typically a pathway to gay identity, though there can be hybrids, such as a sexually celibate Christian who identifies as gay.

Yarhouse anticipates and addresses criticism directed at this conception of congruence from some traditional Christian perspectives.

> Congruence can take many forms. This is one reason why some religious affiliated individuals have criticized SIT; this therapy model doesn't hold out one identity outcome as the prescribed outcome for all clients. The clinician is asked to "get out of the way" of how the client resolves the conflict between religious and sexual identities, so that the decisions that clients make in developing counternarratives and achieving congruence are truly their own. . . . Our goal as clinicians who practice SIT is to value both clients' faith and their same-sex sexuality. What we are trying to do is join clients on a journey as the work to determine how these aspects of their lives best fit together. (p. 137)

The book continues with helpful chapters focusing on working with mixed-orientation couples and with parents subsequent to their teenager coming out as "gay." Four appendices conclude the work, including three case studies so the reader can get a sense of what SIT looks like in practice. Of

particular interest is the appendix that is a reprint of the original SIT framework that was published in 2006 by Yarhouse and Warren Throckmorton. While *Sexual Identity & Faith* adheres fairly closely to this original framework, there are some differences in emphasis that seem noteworthy, which I will explore shortly.

Observations

In many respects, this is a book with which any clinician working with clients who experience conflicts between their faith and sexuality should be familiar. Yarhouse demonstrates appropriate sensitivity to and clinical acumen for the many landmines that can be present in working with this client population. On a strictly practical level, I appreciated the numerous worksheets and suggested clinician language he provides for conducting SIT, much of which can aptly be utilized regardless of whether the therapist strictly adheres to the SIT framework. His work is a service to clinicians looking for a model that may place their therapy under less professional and legal scrutiny than past and present change-oriented therapies. That said, I can imagine some therapists sensing there is more to this field than SIT allows and not feeling fully satisfied with the book generally and the SIT model specifically.

Clinicians looking for any consideration with SIT of potential psychodynamic, developmental, attachment, and childhood trauma influences on same-sex attractions and behaviors will be disappointed. Yarhouse notes early on that he has seen many failed SOCE cases who were taught their SSA is the product of sexual abuse or unmet emotional needs in relationship to their parents: "I didn't think much of these theories for the etiology of same-sex sexuality" (p. xi). Of course this is a problem if clients were coercively "taught" by their therapists any etiological model, but there are clients who gravitate to a particular view because they feel it matches their experience. I hope SIT would not try to reeducate these clients away from their perspectives, although no etiological belief guarantees change.

Yarhouse's reluctance to entertain any etiological role for developmental and/or trauma experiences may relate to a number of factors. As a cognitive-, behavioral-, and narrative-oriented clinician, potential psychodynamic and attachment issues are an unlikely focus of therapeutic interest or exploration. On pages 46–47, Yarhouse lists the kinds of goals that could guide SIT focus, and nowhere is mentioned the assessment and treatment of trauma. Nor is the clinical exploration of traumatic experience or adverse childhood events ever mentioned in the case study material offered. Perhaps such exploration is assumed as a parallel therapeutic focus outside of the SIT domain, but the failure to mention it throughout the book raises concerns. It would also seem plausible that clients who want to explore the degree to which their trauma history may have influenced the development of their same-sex attractions and/or have experienced fluidity in these attractions would be less likely to consult with a CBT-oriented clinician. Individuals who did not benefit from change efforts or who do not report or do not recognize trauma histories may be more likely to self-select for SIT. This may be why he tells clients, "Most people who come to see me have been down that [change approach] road and have not found it to deliver on the promises that were made" (p. 45). This does not mean Yarhouse's observations, derived from the small subset of sexual minority clients with whom he works, cannot be spot on for a number of individuals who have found therapeutic change efforts wanting. However, it is possible he may be overgeneralizing from his clinical experiences to the population of traditionally religious sexual minorities with

conflicts about their SSA who present for therapy, some of whom may report changes in their experience of SSA have been important in their pursuit of personal congruence. Finally, it is hard to imagine that professional status considerations are not also an understandable factor in Yarhouse's reluctance to address or take a clear position on some of the more controversial issues associated with working with this population, such as the influence of childhood trauma on sexual orientation or the possibility of some degree of therapy-assisted fluidity and change for some clients. Surely taking a wrong step on such radioactive issues would jeopardize his position as perhaps the foremost bridge builder between traditional Christian communities and the secular psychological world of the APA and beyond.

Perhaps Yarhouse's limited exposure to a variety of client experiences with change efforts is reflected in his characterization of SOCE, which generally mimics the APA's sentiments. In this caricature, change-allowing therapies attempt to "make gay people straight" and "manipulate orientation" (p. 7). They also have as their goal "a fixed outcome in which clients shift toward a heterosexual orientation" (p. 52). By contrast, SIT is "implicitly integrative" as a model that "does not explicitly align with a value system" (p. xiii) and does not allow therapists' "biases to direct clients toward one path over another" (p. 50). This strikes me as a false dichotomy for at least a couple of reasons.

First, these depictions of SOCE, which no doubt have applied to historical uses of coercive and aversive techniques in religious and professional psychological circles alike, simply have not been a part of change-allowing therapies for decades. Yarhouse does not seem familiar with client experiences of fluidity and change that are not attempts at direct manipulation but rather *emerge* as byproducts of therapeutic work addressing trauma or emotional-relational development. Therapists must be exceedingly careful not to give false hopes of change, but should they not also exercise caution in foreclosing any possibility of sexual attraction fluidity?

Second, positioning SIT as being values neutral seems to me to be a somewhat shallow philosophical stance to take. If stating that SIT does not have a value system is meant to convey the need for therapist sensitivity to the values of clients and to work as much as possible within their value frameworks, then this is good advice. However, strictly speaking, to not have alignment with a values system is, in fact, to adopt very clear value framework from which to do clinical work. If this values-neutral stance of SIT is as thorough going as it is made out to be, then there can never be value conflicts between the client and therapist so stark that it places limits on the therapeutic work or necessitates referral to a clinician with more aligned values. This may be why the book has no guidance for therapists who conceivably could experience such conflicts regarding how best to avoid such situations and/or to orchestrate a referral.

Yarhouse's inclusion as an appendix of his 2006 description of SIT is of particular interest as it provides some contrast to the rest of the book, appearing more balanced in its treatment of SOCE in a therapy context. For example, he acknowledges, ". . . for some clients, exploration of how fluid their sexuality could be is of prime therapeutic interest" (p. 191), and elsewhere even notes some clients report change experiences:

> To varying degrees, some clients may come to believe change has occurred in their sexuality while some will believe little or no change has occurred. These perceived changes can be examined, but we do not view

> such change as a determinant for the success or failure of SIT. (p. 183)

Unlike the book, here Yarhouse and Throckmorton acknowledge in a non-dismissive tone some clients do wish to explore SSA fluidity and report experiencing change. They also affirm the appropriateness of examining this in therapy, with appropriate warnings that change should never be promised or made the only measure of helpful therapy. He later cites a 2002 quote from Douglas Haldeman, which states, "Psychology's role is to inform the profession and the public, not legislate against individuals' rights to self-determination" (p. 186). The full quote makes clear this self-determination includes change-oriented goals. Of course, in a more than ironic twist, Haldeman in 2018 testified in support of California legislation that would have declared any speech construed as promoting change within a fiduciary relationship (including therapists and pastoral counselors) as consumer fraud, encouraging legal action against such providers.

The 2006 SIT paper also makes explicit the inclusion of change-oriented goals in treatment options: "Professional interventions available include an active focus on same-sex identity, efforts to modify erotic orientation, and/or a more integrative approach" (p. 195). Referrals due to value conflicts are likewise allowed, though the risks of doing so are recognized:

> Moreover, if a therapist's value position or professional identity (e.g., gay affirming, conservative Christian) is in conflict with the client's preferred direction, the referral to a more suitable mental health professional may be indicated. (p. 197)

Perhaps most astounding of all, Yarhouse and Throckmorton encourage clinicians to be familiar with a wide range of information and resources to assist clients in informed consent and decision-making, including works by past Alliance leaders Joseph Nicolosi, Sr. and A. Dean Bryd. These are the only references to such authors in the entire book.

These contrasts between the 2006 paper and this 2019 book seem likely to reflect the continued movement in the culture and in organized psychology away from any consideration of change-allowing therapies in favor of outright hostility toward them. This plausibly has placed ever tighter constraints on what Yarhouse might say about change-allowing therapies. Yarhouse is undoubtedly aware that although his immediate audience may be the Christian community, his broader audience includes LGBT+ activists within the APA who would not stomach too much deviation from affirmative models of therapy. For those who wish to maintain credibility within contemporary organized psychology, giving any credence to therapy-assisted SSA fluidity and change or etiological models that do not universally prioritize biological factors and dismiss developmental influences such as trauma is likely a career endangering move and thus professionally untenable.

I will close with one further observation and prediction: the exponential growth in gender dysphoria (particularly among girls) may well test the elasticity of the SIT framework's values neutrality. Yarhouse has already published a book on gender dysphoria, but to my knowledge he has not weighed in on the applicability of SIT for transgender concerns. What does SIT do with clients (including especially minors) who decide personal congruence for them means hormonal treatments and surgical removal of healthy body parts that could result in sterility and potentially serious medical risks? Will

this be a bridge too far, even for SIT, to remain aligned with such clients' goals, leading to a heightened risk of losing credibility within the culture of secular psychology? Or will the SIT framework simply incorporate conflicts between religious values and transgender feelings into its existing template for therapeutic service, likely raising further apprehensions about SIT within the conservative Christian communities Yarhouse intends to reach? I'm not sure it will be possible for SIT to achieve a mutually satisfying resolution to these imminent tensions, but I wish Yarhouse the wisdom of Solomon in navigating them.

This critique of *Sexual Identity & Faith* has admittedly focused on areas of the book that raised some apprehensions for me. However, this should not obscure the fact that there is much good clinicians can glean from Yarhouse's SIT framework, even if it is not adopted in wholesale fashion by the reader. SIT attempts, often successfully, to straddle the fence between the traditional faith-based community and secular psychological associations. This is a worthy endeavor, though it may be reaching its limits as most secular mental health organizations move increasingly toward a sexual world completely unrestrained by Christian values and moral sensibilities beyond that of mutual consent. At least for the time being, however, Yarhouse's book continues to offer a lot of valuable insights and guidance for therapists who encounter in their work clients experiencing conflicts between their faith and their sexuality.