Oregon Psychological Association

To: House Committee on Health Care
From: Dr. Brad Larsen Sanchez, Oregon Psychological Association
Regarding: In support of HB 2307

Good afternoon. My name is Dr. Brad Larsen Sanchez, a licensed psychologist in Oregon. I am the chair of the Diversity Committee of the Oregon Psychological Association and I am here to represent the Oregon Psychological Association in support of the proposed legislation to prohibit licensed mental healthcare professionals from using conversion therapy with minors.

When Basic Rights Oregon approached OPA for support of this proposed legislation, the OPA Diversity Committee, Legislative Committee and Executive Board were broadly supportive of the bill. We requested feedback from our members and the overwhelming response was supportive. A concern was raised relating to setting a precedent for legislating what psychologists do in a therapeutic setting. We believe that this concern is important to note but completely outweighed by the need to support this bill to eliminate dangerous and discredited practices.

Decades of research in psychology affirm that same sex attraction is a normal and positive variation of human sexual orientation. Homosexuality is not a mental disorder; moreover it is not a disorder of any kind. Leading scholars studying trans health conceptualize much of the distress experienced by trans people through processes of minority stress, not an inherent pathology. There is also the body of literature that sites the improvement in mental health after receiving appropriate medical treatments for transition. Regarding conversion therapy, most major medical and mental health professional associations do not support the use of so called reparative therapies for gay and lesbian, and transgender individuals (Attachment 1).

The ethics code for psychologists is consistent with the charge of the Oregon Health Authority; we are required to provide effective, evidence-based treatments that are scientifically informed. In addition, we are required to not actively harm individuals with the treatments we provide (Attachment 2). The research on reparative therapies is abysmal and shows that not only are these methods ineffective, they are harmful (Attachment 3 & 4). Just a couple of weeks ago, New Jersey declared judicially that reparative therapy is the equivalent of consumer fraud (Attachment 5).

The Oregon Psychological Association, along with the nation's leading professional medical, health and mental health organizations, does not support efforts to change young people's sexual orientation or gender identity and have raised serious concerns about the potential harm from such efforts (Attachment 6).

Passing this legislation will reinforce the ethical imperative for psychologists as well as other mental health professionals. Additionally, this legislation will serve to educate and empower the consuming public, especially our youth, to reject the fraudulent and damaging practice of conversion therapy. By passing this legislation you are serving to help protect young people who are often unable to advocate for themselves.

The Oregon Psychological Association is in full support of this bill and strongly encourages its passage.

Attachment 1

AMERICAN PSYCHOLOGICAL ASSOCIATION

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003

With the 2010 Amendments
Adopted February 20, 2010
Effective June 1, 2010

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of

Attachment 2

Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

RESEARCH SUMMARY

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammersmith, 1981; Bullough, 1976; Ford & Beach, 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of *sexual orientation change efforts* (SOCE).[1] SOCE has been controversial due to tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006). Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008b).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the Association. The Task Force reached the following findings.

Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002, Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them to change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orien-

Adopted by the American Psychological Association Council of Representatives

on August 5, 2009.
For more information, please see **www.apa.org/pi/lgbt**.

PLEASE CITE AS:

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tation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the Task Force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities[2] (Herek, 2009; Herek & Garnets, 2007) and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA, 1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

RESOLUTION

WHEREAS the American Psychological Association (APA) expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008b); and

WHEREAS the APA takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008b); and

WHEREAS psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b); and

WHEREAS psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008b); and

WHEREAS those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008b); and

WHEREAS the APA encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008b); and

WHEREAS societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001); and

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

WHEREAS sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan & Futterman, 1997), who lack adequate legal protection from involuntary or coercive treatment (Arriola,

1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciotto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hershberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE BE IT RESOLVED that the APA affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED that the APA reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED that the APA encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents, and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED that the APA advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED that the APA encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity;

BE IT FURTHER RESOLVED that the APA encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma, and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED that the APA opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED that the APA supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation;

BE IT FURTHER RESOLVED that the APA encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the wellbeing of sexual minorities.

ENDNOTES

1. The APA uses the term *sexual orientation change efforts* to describe all means to change sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches). This includes those efforts by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups.
2. The Task Force uses the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because the Task Force recognizes that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

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Attachment 3

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A SYSTEMATIC REVIEW OF THE RESEARCH BASE ON SEXUAL REORIENTATION THERAPIES

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In the past few years, members of the AAMFT, like members of other professional groups, have engaged in a discourse as to the necessity and effectiveness of sexual reorientation therapies. The purpose of this article is to review, critique, and synthesize the scientific rigor of the literature base underpinning sexual reorientation therapy research. Using a systematic narrative analysis approach, 28 empirically based, peer-reviewed articles meeting eligibility criteria were coded for sample characteristics and demographics as well as numerous methodology descriptors. Results indicate the literature base is full of omissions which threaten the validity of interpreting available data.

Prior to the removal of homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 1987), the clinical literature base was replete with studies of therapies aimed at changing sexual orientation based on behavior modification or aversive conditioning procedures. Gradually, however, such studies were discontinued for ethical and legal reasons. With homosexuality depathologized, therapeutic interventions have been developed that are more affirmative of a same-sex orientation (Zucker, 2003).

In contrast, some researchers and therapists have maintained that sexual orientation can be changed and have described techniques that collectively have been considered ''reparative therapy'' or ''conversion therapy'' (Nicolosi, 1991; Socarides & Kaufman, 1994). Based on a psychoanalytic interpretation of homosexual behavior, Nicolosi (1991) suggested that the pathological sexualization was in need of ''repairing,'' thus the term ''reparative'' therapy (Morrow & Beckstead, 2004). Reparative therapy, as a program of psychotherapy, attempts to ''cure'' homosexuals by transforming them into heterosexuals (Hicks, 1999). These therapies can include a myriad of techniques including prayer, religious conversion, and individual or group counseling. In contrast, aversion therapies are techniques which share the same goal but are behavioral in nature, such as shock therapy. Traditional methods of aversion techniques have been termed ''cruel'' (Haldeman, 2002) and would not pass current Institutional Review Board Standards for acceptable research practices. For the purposes of this article, the term ''sexual reorientation'' will be utilized as an umbrella term to describe therapies which are either aversive (behavioral) or reparative (psychosocial). Many believe that these therapies should be available (e.g., Rosik, 2003), while others claim they are unnecessary and harmful (e.g., Green, 2003).

Some authors suggest that it is important to consider religious and spiritual orientations while deciding to recommend or not recommend sexual reorientation therapies (Yarhouse & Throckmorton, 2002). This is predicated on the notion that, while sexual orientation may be

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primarily biological, sexual behaviors are volitional and subject to moral evaluation (Stein, 1996). Some researchers and therapists believe that reorientation therapies may be warranted when an individual's sexual orientation is in conflict with his or her religious beliefs. Several guidelines have been suggested for clinicians to help those individuals who express dissatisfaction with their sexual orientation (Throckmorton, 2002; Yarhouse & Throckmorton, 2002).

Other studies have identified negative consequences of sexual reorientation therapies. For example, Shidlo and Schroeder (2002) noted that a majority of those who sought reparative therapies perceived psychological harm in the form of depression, suicidal ideation and attempts, social and interpersonal harm, loss of social support, and spiritual harm as a direct result of these interventions. Haldeman (2002) also noted typical negative outcomes of reparative therapies that include chronic depression, low self-esteem, difficulty sustaining relationships, and sexual dysfunction. Others (e.g., Haldeman, 2002) have noted that the practice of both types of sexual reorientation therapies socially devalues homosexuality and bisexuality.

Professional organizations such as the American Psychological Association, American Psychiatric Association, American Academy of Pediatrics, American Medical Association, American Counseling Association, National Association of School Psychologists, National Association of Social Workers, and the Royal College of Nursing have adopted policies that reject sexual reorientation therapies due to a lack of evidence for the mental illness view of homosexuality and bisexuality. In fact, the American Psychological Association provides clear guidelines for professionals dealing with clients who struggle with their sexual orientation (American Psychological Association, 2000). The emphasis is on identifying and understanding the client's perception of discrimination due to internalized and external homophobia. Thus, the social and psychological context of discomfort assumes more importance than the clinician's theoretical perspective on sexual orientation or either type of sexual reorientation therapy (Haldeman, 2002).

A survey of the literature reveals numerous other attempts to review and synthesize the literature base in this area (Adams & Sturgis, 1977; Bhugra, 2004; Bieber, 1967; Clippinger, 1974; Drescher, 1998; Haldeman, 1994, 2001; Rogers, Roback, McKee, & Calhoun, 1976; Throckmorton, 1998, 2002). Perhaps because of these two contrasting viewpoints, and despite numerous other attempts to distill consensus on sexual reorientation therapies, "The empirical database remains primitive, and any decisive claim about benefits or harms really must be taken with a substantial grain of salt" (Zucker, 2003, p. 6).

In the past few years members of the AAMFT, like members of other professional groups, have engaged in a discourse as to the necessity and effectiveness of reparative therapies in particular. Fundamental questions which have emerged from these discussions include the following: What are sexual reorientation therapies? Do these therapies work to change sexual orientation? Can these therapies be harmful to individuals or families? The purpose of this research is to address a different question, "*What is the scientific rigor of the studies supporting the conclusions claimed by both sides of the debate?*" We addressed these questions by comprehensively critiquing the available literature base on both types of sexual reorientation therapies dating back to 1956 and revealing the strengths and weaknesses of the research underlying this literature.

METHODOLOGY

A systematic review was chosen for the purposes of addressing the preceding research question. This type of review thoroughly identifies, appraises, and synthesizes relevant studies on a given topic (Petticrew & Roberts, 2006). While a meta-analytic systematic review uses statistical techniques to synthesize results of several studies into an effect size, a narrative systematic review explores studies descriptively (Petticrew & Roberts, 2006). A systematic review is particularly appropriate when researchers are looking to inform clinical practice or seek to critically assess a body of literature (Gough & Elbourne, 2002; Petticrew, 2001).

Sample

The process began by identifying relevant studies to be included in the analysis. Each member of the research team independently searched relevant academic databases, including PsycINFO, Social Science Citation Index, Academic Search Premier Database, and Sociological Abstracts, for articles. In addition, the websites of organizations, such as the National Association for Research and Treatment of Homosexuality (NARTH), Exodus International, and Focus on the Family were also searched for citations of academic research. Multiple terms were used to locate relevant research, including "conversion therapy," "reparative therapy," "sexual orientation therapy," and "sexual reorientation therapy." There was no publication time restriction for the inclusion of articles. In addition, articles, books, and book chapters addressing reparative therapies were carefully reviewed for citations of additional papers. This process resulted in 182 possible candidates for inclusion.

As relevant studies were being acquired, the team developed inclusion criteria. In order for data to be included in the analysis, the research needed to be empirically based and directly address the topic of reparative therapy. Editorials and letters to editors ($n = 3$), commentaries ($n = 26$), and literature reviews ($n = 10$) were excluded. Book chapters and reviews ($n = 23$) as well as case studies ($n = 36$) presented interesting challenges to the inclusion criteria. Book chapters were excluded because they tend not to be peer-reviewed but rather invited. Case studies were deemed problematic and excluded because generalizability is not a goal of such reports. In addition, articles that could not be verified or located within the academic library system ($n = 11$), were not about sexual reorientation therapies ($n = 3$), and only described ethical issues or clinical procedures ($n = 39$) were not included. The final sample of data for this study included 28 empirically based, peer-reviewed full-length articles and brief reports addressing the efficacy of reparative therapies.

A coding sheet was designed by the research team which included issues and variables deemed relevant to the investigation. Items included the research topic, theoretical orientation of the author, sample characteristics, study design, independent and dependent variables, type of analyses, and strengths and weaknesses of the study. Sample characteristics coded included sample size, gender, race, education, income, social class, region of the country, type of sample, dropout or return rate, source of recruitment or sampling, religion, and sexual orientation.

Each of the included articles was coded by a randomly assigned primary and secondary reviewer. The primary reviewer was responsible for the initial written coding of the article which was confirmed, refuted, or accentuated by the second reviewer. After each article was coded, relevant data were entered into a database for analysis.

RESULTS

Frequencies were calculated on the sample demographics for all studies. It is noteworthy that 61% of studies did not report dropout or return rates; 64% did not report age of participants so that a mean could be calculated; 68% did not report educational level of participants; 79% did not report race of participants; 79% did not report region of the country in which the study was conducted; 82% did not report religion of participants; 86% did not report social class, and 100% did not report income.

Type of Studies Conducted

Type of sexual reorientation therapy under investigation was examined and it was noted that 28% ($n = 8$) were "reparative" while 72% ($n = 20$) were "aversion." Reparative therapy included studies of individual psychotherapy or peer support (Beckstead, 2001; Beckstead & Morrow, 2004; Jones, Botsko, & Gorman, 2003; Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Schaeffer, Nottebaum, Smith, Dech, & Krawczyk, 1999; Spitzer, 2003); group psychotherapy or support group (Beckstead, 2001;

Beckstead & Morrow, 2004; Ellis, 1956; Jones et al., 2003; Nicolosi et al., 2000; Schaeffer et al., 1999, 2000; Spitzer, 2003); or prayer/pastoral counseling (Jones et al., 2003; Nicolosi et al., 2000; Schaeffer et al., 1999, 2000; Spitzer, 2003).

Aversion therapy included the use of electroconvulsive shock treatments (Bancroft & Marks, 1968; Conrad & Wincze, 1976; Fookes, 1968; Freeman & Meyer, 1975; Hallam & Rachman, 1972; McConaghy, 1975; McConaghy, Armstrong, & Blaszczynski, 1981; Solyom & Miller, 1965; Tanner, 1973, 1975); injections of drugs to induce nausea or vomiting (McConaghy, 1969, 1975; McConaghy & Barr, 1973); use of noxious stimuli (Maletzky & George, 1973); hypnotic suggestions (Barlow, Agras, Leitenberg, Callahan, & Moore, 1972; Conrad & Wincze, 1976; Hallam & Rachman, 1972; James, 1978; Maletzky & George, 1973; McConaghy et al., 1981); or Orgasmic Reconditioning (ORC) using visual stimuli (Bancroft & Marks, 1968; Barlow & Agras, 1973; Conrad & Wincze, 1976; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Herman, Barlow, & Agras, 1974a, 1974b; McConaghy, 1969, 1975; McConaghy & Barr, 1973; McConaghy et al., 1981; Solyom & Miller, 1965; Tanner, 1973, 1975). Some included the use of a combination of these treatments (Bancroft & Marks, 1968; Conrad & Wincze, 1976; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Maletzky & George, 1973; McConaghy, 1969, 1975, 1976; McConaghy & Barr, 1973; McConaghy et al., 1981; Schmidt, Castell, & Brown, 1965; Solyom & Miller, 1965; Tanner, 1973, 1975). Because of the significant differences between reparative and aversion therapy, and the fact that aversion practices are no longer performed in research environments, type of therapy was treated separately in further analyses.

Results for Reparative Therapy

Reparative therapy studies were published between 1956 and 2004 with 88% in print since 1999. Only one of these studies reported a theoretical foundation for their work (Beckstead & Morrow, 2004), which was grounded theory. The age of participants ranged from 19 to 81 years but as mentioned earlier a mean could not be calculated. None of these studies reported income or social class and only 25% ($n = 2$) reported a dropout rate. These were reported as 32.7% dropout (Schaeffer et al., 1999) and 28% nonresponse rate (Spitzer, 2003). Six of the eight studies (61%) included data on religious affiliation of participants. Of these, four included members of the church of Latter Day Saints (Beckstead, 2001; Beckstead & Morrow, 2004; Nicolosi et al., 2000; Spitzer, 2003); two included samples identifying as Protestant, Catholic, Jewish, and ''other'' (Nicolosi et al., 2000; Spitzer, 2003) or reported a generic ''Christian'' sample (Schaeffer et al., 2000).

These studies were conducted with rather large samples ($R = 20–882$; $M = 272$). Male samples ($R = 18–689$; $M = 175$) were notably larger than female samples ($R = 20–400$; $M = 96$). Two of the largest studies included samples of 882 (Nicolosi et al., 2000) and 600 (Jones et al., 2003). Nicolosi and colleagues (2000) recruited participants using a snowball technique. Surveys were distributed to reparative therapists and their identifiable clients and through the National Association for Research and Therapy of Homosexuality (NARTH). These therapists and clients were also asked to provide surveys to current and previous clients. In addition, surveys were distributed to members of ex-gay ministry groups, and information about the study was placed in their newsletters or announced at associated conferences. Data for the Jones study came from a preexisting data set of lesbians, gay men, and bisexuals ''who had been in psychotherapy at some time in their lives'' (Jones & Gabriel, 1999, p. 211).

Of those who reported source of referral or sampling ($n = 7$), 43% used self-referral methods (Beckstead, 2001; Jones et al., 2003; Nicolosi et al., 2000) and 85% used professional referral sources (Beckstead, 2001; Ellis, 1956; Nicolosi et al., 2000; Schaeffer et al., 1999, 2000; Spitzer, 2003) or both. Professional referral sources were typically psychologists (Ellis, 1956; Nicolosi et al., 2000; Spitzer, 2003) or ministers (Nicolosi et al., 2000; Schaeffer et al., 1999, 2000; Spitzer, 2003).

Race of participants was reported in 62% of the studies, and the majority included only Caucasians (R = 86–100%; M = 93%). Percent of African Americans included in samples ranged from 1% to 2% (M = 1.7%). Hispanics were included at a slightly higher rate (R = 1–7%; M = 4.2%), as were Asians (2–3%; M = 2.5%); however, no study reported including Native Americans.

Region of the country in which samples were selected was reported in 75% of the studies, and results varied. California was mentioned in three studies (Jones et al., 2003; Nicolosi et al., 2000; Schaeffer et al., 1999). Two studies included residents of Utah (Beckstead, 2001; Beckstead & Morrow, 2004) or New York (Jones et al., 2003; Nicolosi et al., 2000) while the states of Texas (Nicolosi et al., 2000), Washington (Nicolosi et al., 2000), Florida (Nicolosi et al., 2000), Kentucky (Schaeffer et al., 1999), and Colorado (Schaeffer et al., 1999) were each mentioned once. One study reported, "Participants lived mainly in the United States (East 14%, West 35%, Midwest 15%, South 25%), with the remaining 16% mostly in Europe" (Spitzer, 2003, p. 406).

Level of education was reported in 75% of the studies; however, wide differences emerged on how education was reported such that a concise summary is difficult. Two studies reported a mean for the overall sample of 12 years of education (Schaeffer et al., 1999, 2000). Two studies reported mean years of education by gender and the results were virtually identical. In one study, the mean education level for males was 15.70 and for females 14.79 (Schaeffer et al., 1999) and for the other the mean education level for males and females was 15.69 and 14.72, respectively (Schaeffer et al., 2000). One study reported the percent completing college (76%) (Spitzer, 2003), while another reported those participants completing college (90%) or graduate degrees (62%; Jones et al., 2003). The remaining studies reported much greater detail on educational background of participants. In one study, 27% had graduate degrees, 11% had some graduate training, 30% had a bachelor's degree, 21% had some college education (Nicolosi et al., 2000), and in the other one person completed grade school; 10 were high school graduates; 23 had some college training; 6 had graduate work (Ellis, 1956).

Of those who reported a measure of sexual orientation (n = 6), 33% (Schaeffer et al., 1999, 2000) used the Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948), 50% used self-identification (Beckstead, 2001; Jones et al., 2003; Spitzer, 2003), and 17% used a behavioral measure (Ellis, 1956). A variety of dependent measures was used. Three studies utilized subjective report of experience or outcome (Beckstead & Morrow, 2004; Ellis, 1956; Jones et al., 2003). For example, Beckstead and Morrow (2004) asked participants to describe how therapy helped them. Ellis (1956) subjectively determined improvement "by the judgment of the investigator" (p. 193). Five studies included subjective report of change in identity or orientation (Beckstead, 2001; Nicolosi et al., 2000; Schaeffer et al., 1999, 2000; Spitzer, 2003). Beckstead (2001) asked participants whether they had become "exclusively heterosexual" (p. 93) and Schaeffer et al. (2000) "included both closed and open-ended questions about sexual orientation" (p. 63). Two studies included measures of psychological functioning, including depression and self-esteem (Nicolosi et al., 2000) and tension, paranoia, and guilt (Schaeffer et al., 1999). Finally, three studies included measures of behavioral functioning (Nicolosi et al., 2000; Schaeffer et al., 1999; Spitzer, 2003). Examples included asking the participant to rate his or her current sexual functioning on a 7-point Likert scale (Nicolosi et al., 2000) and "How often did you have homosexual sex" (Spitzer, 2003, p. 415).

Results for Aversion Therapy

Aversion therapy studies were published between 1965 and 1981 with 90% in print before 1976. A primary theoretical orientation was clearly present in seven (35%) of the studies (Freeman & Meyer, 1975; Hallam & Rachman, 1972; Herman et al., 1974b; McConaghy & Barr, 1973; McConaghy et al., 1981; Schmidt et al., 1965; Solyom & Miller, 1965). Orientations included classical conditioning (Freeman & Meyer, 1975; Herman et al., 1974b), behavioral

(McConaghy et al., 1981; Solyom & Miller, 1965), aversion (Hallam & Rachman, 1972; McConaghy & Barr, 1973; Solyom & Miller, 1965), and learning theory (Schmidt et al., 1965).

Age of participants ranged from 15 to 62 years, but in 70% of the cases a mean could not be determined. Only 15% of studies reported details on education level of participants. Education was reported as describing two subjects as college students (Conrad & Wincze, 1976), having average intelligence (Hallam & Rachman, 1972), and a description of one subject as having been in college (Herman et al., 1974b). Remarkably, no study reported race, income, region of the country, or religion.

Of those who reported a measure of sexual orientation ($n = 12$), 92% used self-identification (Barlow & Agras, 1973; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Herman et al., 1974a, 1974b; McConaghy, 1975, 1976; McConaghy et al., 1981; McConaghy & Barr, 1973; Schmidt et al., 1965; Solyom & Miller, 1965; Tanner, 1973), and one used a behavioral measure (Conrad & Wincze, 1976). Dependent measures used in aversion therapy articles also varied widely. Three studies utilized subjective report of experience or outcome (Fookes, 1968; McConaghy et al., 1981; Schmidt et al., 1965). Examples included "the unrefuted claim of the patient to have lost the desire for the perversion" (Fookes, 1968, p. 340) and "the patient's awareness of the amount of sexual interest in men and women and the amount and nature of sexual fantasy, including masturbatory fantasy" (McConaghy et al., 1981, p. 430). Three studies included subjective report of change in identity or orientation (Freeman & Meyer, 1975; Herman et al., 1974b; James, 1978). Examples included self-report using the Kinsey Scale and an estimation of the subject's percent of sexual attraction toward males (Freeman & Meyer, 1975) and self-report on the Sexual Orientation Method questionnaire designed to assess the relative levels of homo- and heteroerotic orientation (Herman et al., 1974b). Three studies included measures of psychological functioning, including a mood scale (Hallam & Rachman, 1972), a social anxiety rating questionnaire to assess the degree of social and heterosexual phobia (James, 1978), and scores from Scale 5 "masculinity-femininity" of the MMPI (Tanner, 1975). Nine studies included measures of behavioral functioning (Bancroft & Marks, 1968; Barlow & Agras, 1973; Conrad & Wincze, 1976; Freeman & Meyer, 1975; Herman et al., 1974a, 1974b; Maletzky & George, 1973; McConaghy, 1969; Tanner, 1975). Examples included the use of the Kinsey Scale (Freeman & Meyer, 1975; James, 1978; Maletzky & George, 1973), the subject recording the daily frequency of sexual urges, sexual fantasies, and sexual contacts of any nature (Conrad & Wincze, 1976), and a temptation test where a same-sex confederate employed by the therapist would approach the subject and solicit sex. If the subject turned down the approach, he passed (Maletzky & George, 1973). Finally, physiological arousal was measured in 12 studies and these included penile circumference (Barlow & Agras, 1973; Barlow et al., 1972; Conrad & Wincze, 1976; Freeman & Meyer, 1975; Herman et al., 1974a, 1974b; McConaghy, 1969, 1975, 1976; Tanner, 1973), heart rate (Hallam & Rachman, 1972), and skin resistance or response (Hallam & Rachman, 1972; Solyom & Miller, 1965).

Nine (45%) studies reported dropout rates (Bancroft & Marks, 1968; Freeman & Meyer, 1975; Herman et al., 1974b; McConaghy, 1969; McConaghy & Barr, 1973; McConaghy et al., 1981; Schmidt et al., 1965; Solyom & Miller, 1965; Tanner, 1973). These were reported differently across studies. For example, Schmidt et al. (1965) reported a 24% dropout rate, Solyom and Miller (1965) reported that two out of six participants discontinued treatment, and McConaghy and Barr (1973) reported that "only 20 of 46 patients completed all booster treatments" (p. 159).

The samples utilized in these studies were not as large as those in the talk therapy literature. Overall samples ranged from 3 to 157 with 95% of the studies having a sample of 47 participants or less ($M = 26$). As might be expected, male samples ($R = 3$–157; $M = 25$) were notably larger than female samples. Only one study included females ($n = 11$; Schmidt et al., 1965). Of those who reported source of referral or sampling ($n = 17$), 53% used self-referral and 65% used professional referral sources.

DISCUSSION

The primary aim of this project was to examine the manner in which research on the topic of reparative therapy has been conducted and subsequently reported. Of primary interest was the rigor in which the science supporting each study had been conducted. Most notable in these results was the degree to which important omissions in the data occurred. These omissions were most pronounced in terms of describing the demographic characteristics of the available samples. While it is impossible to assess whether the missing data were not gathered or just not reported, it is likely that some omissions are an artifact of publishing in the 1960s and 1970s. That is, inclusion of religious orientation, income, or race may have been perceived as unimportant to researchers, reviewers, and editors of that generation. Furthermore, researchers rooted in behavior modification principles would find little theoretical value in providing these descriptors.

Regardless of why the data are missing, the aforementioned methodological oversights are problematic because without adequate information, generalization of study data is limited. For example, 79% of studies did not report the race of their samples and thus conclusions cannot be drawn about the outcomes of these approaches for Caucasians or minorities. Similarly, 64% of studies did not report age of participants such that a mean could be calculated or meaningful age distributions developed. Thus, any differential influence of these approaches on individuals of varying ages or generations cannot be assessed. Most notable, however, is that 61% of studies did not report dropout or return rates. This makes drawing conclusions about treatment effectiveness extremely difficult, if not impossible. Finally, only one aversion therapy study included women, so nothing can be concluded about the use of aversion therapy with women.

One strength of some studies was ample sample sizes. The aversion studies were based on a total sample of just over 400 cases while the reparative samples totaled over 2,100 cases. These studies, however, did not provide explicit inclusion or exclusion criteria or information on respondent tracking (Nicolosi et al., 2000; Spitzer, 2003). Typical sampling strategies included advertising or recruiting at large conferences, soliciting support group attendees, therapist referrals, print and web-based media advertising, and word of mouth (Nicolosi et al., 2000; Schaeffer et al., 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). Limited information regarding inclusion criteria and respondent tracking, however, created difficulty in determining how many men and women would have been eligible to participate in these studies or how many were approached/recruited more than once. For example, when data were collected over multiple years at conferences (e.g., Schaeffer et al., 2000) or multiple organizations (e.g., Nicolosi et al., 2000), it was unclear what strategies were in place to reduce individuals from repeatedly completing questionnaires. Informed consent procedures were rarely mentioned, and often there was no mention of maintaining a list of individuals who had been approached and completed the study in order to limit duplicate sampling.

A major limitation of the studies was that they did not include control groups nor were longitudinal follow-up designs employed. Control group designs are important as they allow for a stronger test of intervention effects and an ability to control for confounding variables. When assessing the impact of an intervention, solid research designs also include clearly timed follow-up assessments. Repetitive post-intervention evaluations allow for test of the intervention's impact and sustainability. In addition, articles describing the aversion therapies provided adequate detail of the procedures utilized to ensure replication. In contrast, many of the reparative therapies have not been manualized or contain various techniques that prohibit comparing the interventions for meta-analytic purposes.

Further, only seven articles on aversion therapy and one reparative therapy article articulated a theoretical approach to their work. Of those reporting a theoretical framework, most were behavioral in nature. This lack of a theoretical rationale in a majority of the reported

studies was disturbing. A solid theoretical justification for using a specific intervention not only provides a framework for future replication, but it also ensures the ethical treatment of participants. Furthermore, the application of theory allows phenomena under investigation to be placed in a context versus sorted and classified.

It is also notable that 75% of the reparative therapy studies and 60% of the aversion therapy studies reported a measure of sexual orientation. Of those that did utilize a measure of sexual orientation, these measures varied considerably in quality. The Kinsey Scale (1948), one of the premier measures of sexual orientation, was used in only three studies. It is interesting that researchers seemed to prefer participants' self-identification as gay or not gay as a measure of sexual orientation. Given the complexities of sexual identity (Klein, Sepekoff, & Wolf, 1985), this minimizes the usefulness of the research base. In studies which allowed participants to self-identify as gay or not, the definition was primarily behaviorally oriented. That is, questions were more likely to probe sexual activity versus any dimension of identity. In addition, the outcomes of the therapies often focused only on the decrease or elimination of "homosexual" thoughts and behaviors. This is problematic because persons may not engage or wish to engage in same-sex behaviors, but they may still identify as not heterosexual based on their partner preferences or emotional attraction. Klein and colleagues (1985) theorized that a person's sexual orientation can change remarkably through the lifetime, and that no one set of sexual behaviors is sufficient to identify a person's sexual orientation. Sexual behaviors are therefore only one component in measuring sexual orientation, along with thoughts, fantasies, and affective responses.

Numerous other options regarding the measuring of sexual orientation exist based on the above assumption. One of the more popular and robust was developed by Klein and colleagues (1985). The Klein Sexual Orientation Grid (KSOG) is composed of seven dimensions of sexual orientation. These dimensions include sexual attraction, behavior, and fantasies, emotional and social preferences, self-identification, and heterosexual/homosexual lifestyle. The KSOG consists of a seven-point response scale, which ranges from "*exclusively heterosexual*" to "*exclusively homosexual*." Respondents are asked to answer each dimension from their past, present, and ideal experiences.

There are numerous benefits of using the Kinsey or Klein measures versus just asking one's sexual orientation; however, these measures were not used. First, Kinsey's instrument allows for a continuum between "*exclusive heterosexuality*" and "*exclusive homosexuality*." Second, the KSOG takes into consideration that one's self-identification may differ from sexual attraction or sexual fantasies. This measure also recognizes that sexual attraction is not synonymous with sexual behavior and that individuals can be attracted to one gender while engaging in sexual behaviors with the other. Third, the KSOG examines each dimension at different times in one's life. Klein's instrument emphasizes that individuals can undergo a significant change in sexual fantasies during their lifetime and this measure is able to collect data at three different points.

ETHICAL ISSUES

For proponents of reorientation therapies a natural question would be "How can we do better research on reparative therapies?" The results of the present study would offer clear directives to those who seek to conduct more sophisticated studies. This includes the assessment of pertinent demographic variables; clearly defined methods of recruitment, retention, and data collection; manualizing of procedures, as well as the use of longitudinal research designs. It would be remiss, however, if the ethics behind such decisions were not explored. First, prior research testing the effectiveness of reparative therapy seems to be methodologically flawed, so application of these results may be misinterpreted. The important question to be pondered is should we be conducting a type of therapy that is not clinically sanctioned by professional

organizations and whose underpinning research base is not clinically sound? According to Tozer and McClanahan (1999), "many proponents of conversion therapy themselves admit that it is not possible to reorient someone to heterosexuality" (p. 729). Men and women who seek to change incongruent or problematic sexual behaviors should be informed that the efficacy of these therapies has not been proven, and that the research regarding such therapies is methodologically flawed. Moreover, the theory and practice of conversion therapy violates principles of competence, integrity, respect for individual rights and dignity, and social responsibility (Tozer & McClanahan, 1999). Second, many proponents of reparative therapy cite older aversion therapy studies as proof of effectiveness. Aversion therapy is easily replicated and use of the plethesmograph which assesses penile engorgement has long been considered the "gold standard" outcome measure. However, while sexual arousal may be extinguishable, at least for short periods of time and under clinical conditions, equating arousal with sexual orientation is erroneous. Furthermore, aversion therapy has been found to be unethical by most professional therapeutic organizations; thus conclusions based on this work may be harmful to clients.

Supporters of reparative therapy have argued that a lack of clinical options when clients seek support for unwanted homoerotic attractions places professionals in a precarious position (Rosick, 2003). Persons with "unwanted" same-sex attractions do present in therapy and couple and family therapists are frequently not trained regarding a course of therapy for these persons. Under these conditions clients should be referred to more experienced clinicians. It would be difficult, and possibly unethical, to deter those clients seeking to resolve a conflict in their sexual orientation through reparative therapy (Haldeman, 2002). Options, however, do exist as the American Psychological Association (2000), National Association of Social Workers, National Committee on Lesbian and Gay Issues (1992), and the American Counseling Association (Whitman, Glosoff, Kocet, & Tarvydas, 2006) have all detailed specific guidelines for working with sexual minorities that include an understanding of how social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients. The understanding of social stigmatization must also include a meaningful understanding of sexual orientation, and such an understanding is critical for therapists if they are to address the psychological issues and multiple stressors that sexual minorities may face.

There are numerous other ethical issues to consider when working with gay, lesbian, and bisexual (GLB) men and women. A few of these concerns are the delivery of services, clinician's competence in treating this population, the diversity of the clientele, and the ethics of sexual reorientation therapies (Greene, 2006). Brown (1996) argues that long-standing discrimination against sexual minorities in the mental health field continues to complicate the delivery of services to this population. It is important that therapists can identify and understand the unique stressors that GLB men and women encounter. Rosario, Shrimshaw, Hunter, and Gwadz (2002) define gay-related stress as the stigmatization of being, or being perceived to be, GLB in a society in which homosexuality is negatively sanctioned. These stressors can include discrimination (Ross, 1990) and experiences of violence (Comstock, 1991) leading to poor mental health outcomes (Meyer, 1995). Shidlo and Schroeder (2002) provide detailed suggestions for clinicians who work with individuals who are considering sexual reorientation therapies. They specifically describe the ethical imperatives for the clinician who pursues sexual reorientation therapy.

CONCLUSIONS

In this critical appraisal of the literature underpinning the research on reparative therapy, a number of methodological problems were identified, which suggests that the scientific rigor in these studies is lacking. The limitations include a lack of theory, inconsistent definition and measurement of sexual orientation, restricted samples, lack of longitudinal designs, and sex disparity. In order for sexual orientation research to progress, the research must be based on a theoretical

framework, must include a standardized definition and measure of sexual orientation, and must include a more gender-balanced sample of heterosexuals, homosexuals, and bisexuals.

Finally, if sexual reorientation therapies are to be fully accepted and embraced as valid, two other important issues need to be addressed. First, studies should be designed to test not only the long-term effect of intervention but also clinicians' ability to demonstrate reversibility of reorientation therapies. That is, can individuals who are reportedly converted to a heterosexual identity and not satisfied be reoriented back to a homosexual identity? Second, the methodological flaws identified here lead to several questions for researchers and clinicians to consider. The main one among them is regarding the validity of interventions based on a flawed empirical database. Future researchers are also challenged with contemplating whether reorientation therapy can be or should be equally applied, available, and shown to be effective with those claiming a heterosexual identity. These questions could also serve as a platform from which clinicians examine the ethical underpinnings of their work in the area.

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APPENDIX

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Attachment 4

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

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CONTENTS

3. A SYSTEMATIC REVIEW OF RESEARCH ON THE EFFICACY OF SOCE: OVERVIEW AND METHODOLOGICAL LIMITATIONS

Although the charge given to the task force did not explicitly call for a systematic review of research on the efficacy and safety of sexual orientation change efforts (SOCE), we decided in our initial deliberations that such a review was important to the fulfillment of our charge. First, the debate over SOCE has centered on the issues of efficacy, benefit, and harm. Thus, we believe it was incumbent on us to address those issues in our report. We attempt to answer the following questions in this review:

- Do SOCE alter sexual orientation?
- Are SOCE harmful?
- Do SOCE result in any outcomes other than changing sexual orientation?

Second, systematic literature reviews are frequently used to answer questions about the effectiveness of interventions in health care to provide the basis for informed treatment decisions (D. J. Cook, Mulrow, & Haynes, 1998; Petticrew, 2001). Current criteria for effective treatments and interventions are specific in stating that to be considered effective, an intervention has consistent positive effects without serious harmful side effects (Beutler, 2000; Flay et al., 2005). Based on Lilienfeld's (2007) comprehensive review of the issue of harm in psychotherapy, our systematic review examines harm in the following ways:

- Negative side effects of treatment (iatrogenic effects)
- Client reports of perceptions of harm from treatment
- High drop-out rates
- Indirect harm such as the costs (time, energy, money) of ineffective interventions

Finally, we were charged to "inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions." We decided that a systematic review[24] would likely be the only effective basis for APA's response to advocacy groups for SOCE.

In our review, we considered only peer-reviewed research, in keeping with current standards for conducting scientific reviews (see Khan, Kunz, Kleijnen, & Antes, 2003), which exclude the grey literature[25] and lay material. In this chapter, we provide an overview of the review and a detailed report on the methodological concerns that affect the validity[26] of the research. In the next chapter, we present our review of the outcomes of the research.

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

[25] Grey literature refers to any publication in any format published outside of peer-reviewed scientific journals.

[26] Validity is defined as the extent to which a study or group of studies produce information that is useful for a specific purpose. It also includes an overall evaluation of the plausibility of the intended interpretations—in this case, does SOCE produce a change in sexual orientation (see American Educational Research Association, APA, & National Council on Measurement in Education, 1999).

Overview of the Systematic Review

Our review included peer-reviewed empirical research on treatment outcomes published from 1960 to the present. Studies were identified through systematic searches of scholarly databases including PsycINFO and Medline, using such search terms as *reparative therapy*, *sexual orientation*, *homosexuality*, and *ex-gays* cross-referenced with treatment and therapy. Reference lists from all identified articles were searched for additional nonindexed, peer-reviewed material. We also obtained review articles and commentaries and searched the reference lists from these articles to identify refereed publications of original research investigations on treatment of same-sex attraction that had not been identified via the aforementioned procedures. In all, we obtained and reviewed original publications of 83 studies. The reviewed studies are listed in Appendix B.[27]

The vast majority of research on SOCE was conducted prior to 1981. This early research predominantly focused on evaluating behavioral interventions, including those using aversive methods. Following the declassification of homosexuality as a mental disorder in 1973 (American Psychiatric Association, 1973) and subsequent statements of other mental health professional associations, including APA (Conger, 1975), research on SOCE declined dramatically. Indeed, we found that the peer-reviewed empirical literature after 1981 contains no rigorous intervention trials on changing same-sex sexual attractions.

There is a small, more recent group of studies conducted since 1999 that assess perceived effects of SOCE among individuals who have participated in psychotherapy as well as efforts based in religious beliefs or practices, including support groups, faith healing, and prayer. There are distinct types of research within this recent literature. One type focused on evaluating individuals' positive accounts of sexual orientation change (Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003). Another type examined potential harm of SOCE and experiences of those who seek sexual orientation (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002). A third type is high-quality[28] qualitative research investigations that provide insight into people's experiences of efforts aimed at altering their same-sex sexual attractions (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkimir, 2001).[29]

In all areas of intervention evaluation, the quality of the methods used in the research affects the validity and credibility of any claims the researcher can make about whether the intervention works, for whom it works, and under what circumstances it works. Many have described methodological concerns regarding the research literature on sexual orientation change efforts (e.g., Cramer, Golom, LoPresto, & Kirkley, 2008; Haldeman, 1994; S. L. Morrow & Beckstead, 2004; Murphy, 1992; Sandfort, 2003). Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

Overall, we found that the low quality of the research on SOCE is such that claims regarding its effectiveness and widespread applicability must be viewed skeptically.

As shown in Appendix B, few studies on SOCE produced over the past 50 years of research rise to current scientific standards for demonstrating the efficacy of psychological interventions (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Flay et al., 2005; Shadish, Cook, & Campbell, 2002; Society for Prevention Research, 2005) or provide for unambiguous causal evidence regarding intervention outcomes. Indeed, only six studies, all conducted in the early period of research, used rigorous experimental[30] procedures. Only one of these experiments (Tanner,

[27] A meta-analytic review of 14 research articles (Byrd & Nicolosi, 2002) is not discussed in this report. The review suffers from significant methodological shortcomings and deviations from recommended meta-analytic practice (see, e.g., Durlak, Meerson, & Ewell-Foster, 2003; Lipsey & Wilson, 2001) that preclude reliable conclusions to be drawn from it. However, studies that were included in the meta-analysis and were published in refereed journals between 1960 and the present are included and described in the current review. Additionally, a recent study (Byrd, Nicolosi, & Potts, 2008) is not included, as it was published after the review period and appears to be a reworking of an earlier study by Nicolosi, Byrd, and Potts (2000).

[28] These studies meet the standards of research rigor that are used for the qualitative research paradigms that informed each of the studies (e.g., grounded theory, ethnomethodology, phenomenology).

[29] These studies are discussed more thoroughly in later sections of the report.

[30] True experiments have more methodological rigor because study participants are randomly assigned to treatment groups such that individual differences are more equally distributed and are not confounded with any change resulting from the treatment. Experiments are also rigorous because they include a way for the researcher to determine what would have happened in the absence of any treatment (e.g., a counterfactual), usually through the use of a no-treatment control group. Quasi-experimental designs do not have random assignment but do incorporate a comparison of some kind. Although they are less rigorous than experiments, quasi-experiments, if appropriately designed and conducted, can still provide for reasonable causal conclusions to be made.

1974) assessed treatment outcomes in comparison to an untreated control group. Only three additional studies used strong quasi-experimental procedures such as a nonequivalent comparison group (see Appendix B). All of these studies were also from the early period. The rest of the studies that we reviewed are nonexperimental (see Appendix B). We thus concluded that there is little in the way of credible evidence that could clarify whether SOCE does or does not work in changing same-sex sexual attractions.

The studies in this area also include a highly select group of people who are unique among those who experience same-sex sexual attractions. Thus, psychologists should be extremely cautious in attributing success to SOCE and assuming that the findings of the studies of it can be applied to all sexual minorities. An overview of the methodological problems in determining the effects of SOCE and making treatment decisions based on findings from these studies follows.

Methodological Problems in the Research Literature on SOCE

Problems in Making Causal Claims

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

INTERNAL VALIDITY CONCERNS

Internally valid research convincingly demonstrates that a cause (such as SOCE) is the only plausible explanation for an observed outcome such as change in same-sex sexual attractions. Lack of internal validity limits certainty that observed changes in people's attitudes, beliefs, and behaviors are a function of the particular interventions to which they were exposed. A major limitation to research on SOCE, both the early and the recent research, stems from the use of weak research designs that are prone to threats to internal validity. Research on SOCE has rarely used designs that allow for confident conclusions regarding cause-and-effect relationships between exposure to SOCE and outcomes.

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

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

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

Common threats to internal validity in early studies include history (i.e., other events occurring over the same time period as the treatment that could produce the results in the absence of the intervention), regression (i.e., extreme scores are typically less extreme on retest in the absence of intervention), and testing (i.e., taking a test once influences future scores on the test in the absence of intervention). Within-subject and patient case studies are the most common designs in the early SOCE research (see Appendix B). In these designs, an individual's scores or clinical status prior to treatment is compared with his or her scores or status following treatment. These designs are particularly vulnerable to internal validity threats, notably threats to internal validity due to sample attrition and retrospective pretests.

Sample attrition

Early research is especially vulnerable to threats to internal validity related to sample attrition. The proportions of participants in these studies who dropped out of the intervention and were lost to follow-up are unacceptably high; drop-out rates go as high as 74% of the initial study sample. Authors also reported high rates of refusal to undergo treatment after participants were initially enrolled in the studies. For instance, 6 men in Bancroft's (1969) study refused to undergo treatment, leaving only 10 men in the study. Callahan and Leitenberg (1973) reported that of 23 men enrolled,

7 refused and 2 dropped out of treatment; 8 also showed inconsistent baseline responses in penile arousal to the experimental stimuli so could not be included in the analysis, leaving only 6 subjects on whom treatment analyses could be performed. Of 37 studies reviewed by H. E. Adams and Sturgis (1977), 31 studies lost from 36% to 58% of the sample. In many studies, therefore, what appear to be intervention effects may actually reflect systematic changes in the composition of the study sample; in the handful of available comparison group studies, differences between the groups in the studies in the rate of dropout and in the characteristics of those who drop out may be the true cause of any observed differences between the groups. Put simply, dropout may undermine the comparability of groups in ways that can bias study outcomes.

Retrospective pretest

With the exception of prospective ethnographic studies (e.g., Ponticelli, 1999; Wolkomir, 2001), the recent research relies exclusively on uncontrolled retrospective pretest designs. In these studies, people who have been exposed to SOCE are asked to recall and report on their feelings, beliefs, and behaviors at an earlier age or time and are then asked to report on these same issues at present. Change is assessed by comparing contemporary scores with scores provided for the earlier time period based on retrospective recall. In a few studies, LMHP who perform SOCE reported their view of how their clients had changed. The design is problematic because all of the pretest measures are not true pretests but retrospective accounts of pretest status. Thus, the recent research studies on SOCE have even weaker designs than do nonexperimental studies from the early period of research on SOCE. Again, none of these recent studies can establish whether SOCE is efficacious.

An extensive body of research demonstrates the unreliability of retrospective pretests. For example, retrospective pretests are extremely vulnerable to response-shift biases resulting from recall distortion and degradation (Schwarz & Clore, 1985; Schwartz & Rapkin, 2004). People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall.

Retrospective pretests are also vulnerable to biases deriving from impression management (Fisher & Katz, 2000; Schwarz, Hippler, Deutsch, & Strack, 1985; Wilson & Ross, 2001), change expectancy (Hill & Betz, 2005; Lam & Bengo, 2003; Norman, 2003; M. A. Ross, 1989; Sprangers, 1989), and effort justification (Aronson & Mills, 1959; Beauvois & Joule, 1996; Festinger, 1957). Individuals tend to want to present themselves in a favorable light. As a result, people have a natural tendency to report on their current selves as improved over their prior selves (impression management). People will also report change under circumstances in which they have been led to expect that change will occur, even if no change actually does occur (change expectancy) and will seek to justify the time and effort that they have made in treatment to reduce any dissonance they may feel at experiencing no or less change than they had expected by overestimating the effectiveness of the treatment (effort justification). Effort justification has been demonstrated to become stronger as intervention experiences become more unpleasant. In combination, these factors lead to inaccurate self-reports and inflated estimates of treatment effects, distortions that are magnified in the context of retrospective pretest designs.

CONSTRUCT VALIDITY CONCERNS

Construct validity is also a significant concern in research on SOCE. Construct validity refers to the degree to which the abstract concepts that are investigated in the study are validly defined, how well these concepts are translated into the study's treatments and measures, and, in light of these definitional and operational decisions, whether the study findings are appropriately interpreted. For instance, do the researchers adequately define and measure sexual orientation? Are their interpretations of the study results regarding change in sexual orientation appropriate, given how the constructs were defined and translated into measures? On the whole, research on SOCE presents serious concerns regarding construct validity.

Definition of sexual orientation

Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity. Modern research of sexual orientation is usually seen as beginning with the Kinsey studies (Kinsey et al., 1948, 1953). Kinsey used a unidimensional, 7-category taxonomic continuum, from 0 (*exclusively heterosexual*) to 6 (*exclusively homosexual*), to classify his participants. As the research has developed since the Kinsey studies, the assessment of sexual orientation has focused largely on measuring three variables—identity,

behavior, and attraction. Many studies measure only one or two, but very seldom all three, of these aspects.

A key finding in the last 2 decades of research on sexual orientation is that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways (Carrillo, 2002; Diamond, 2003, 2006; Dunne, Bailey, Kirk, & Martin, 2000; Laumann, Gagnon, Michael, & Michals, 1994; Savin-Williams, 2005). For instance, individuals with sexual attractions may not act on them or may understand, define, and label their experiences differently than those with similar desires because of the unique cultural and historical constructs regarding ethnicity, gender, and sexuality (Harper et al., 2004; Mays & Cochran, 1998; Walters, Simoni, & Horwath, 2001; Weinrich & Williams, 1991).

Further, a subset of individuals who engage in same-sex sexual behaviors or have same-sex sexual attractions do not self-identify as LGB or may remain unlabeled and some self-identified lesbian and gay individuals may engage in other-sex sexual behaviors without self-identifying as bisexual or heterosexual (Beckstead, 2003; Carrillo, 2002; Diamond, 2003, 2008; Diamond & Savin-Williams, 2000; Dunne et al., 2000; Fox, 2004; Gonsiorek, Sell, & Weinrich, 1995; Hoburg, Konik, Williams, & Crawford, 2004; Kinsey et al., 1948, 1953; Klein et al., 1985; Masters & Johnson, 1979; McConaghy, 1987; McConaghy, 1999; McConaghy, Buhrich, & Silove, 1994; Storms, 1980; Thompson & Morgan, 2008). Thus, for some individuals, personal and social identities differ from sexual attraction, and sexual orientation identities may vary due to personal concerns, culture, contexts, ethnicity, nationality, and relationships.

A number of scholars have argued that the construct of sexual orientation would be more easily and reliably assessed and defined if it were disentangled from sexual orientation identity.

As a result, a number of scholars have argued that the construct of sexual orientation would be more easily and reliably assessed and defined if it were disentangled from sexual orientation identity (e.g., Chang & Katayama, 1996; Drescher, 1998a, 1998b; Drescher, Stein, & Byne, 2005; Rust, 2003; Stein, 1999; R. L. Worthington, Savoy, Dillon, & Vernaglia, 2002). Recent research has found that distinguishing the constructs of sexual orientation and sexual orientation identity adds clarity to an understanding of the variability inherent in reports of these two variables (R. L. Worthington et al., 2002; R. L. Worthington & Reynolds, 2009).

We adopted this current understanding of sexuality to clarify issues in the research literature. For instance, *sexual orientation* refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings, such as "falling in love." Other dimensions commonly attributed to sexual orientation (e.g., sexual behavior with men and/or women; social affiliations with LGB or heterosexual individuals and communities, emotional attachment preferences for men or women, gender role and identity, lifestyle choices) are potential correlates of sexual orientation rather than principal dimensions of the construct.

Sexual orientation identity refers to acknowledgment and internalization of sexual orientation and reflects self-exploration, self-awareness, self-recognition, group membership and affiliation, culture, and self-stigma. Sexual orientation identity involves private and public ways of self-identifying and is a key element in determining relational and interpersonal decisions, as it creates a foundation for the formation of community, social support, role models, friendship, and partnering (APA, 2003; Jordan & Deluty, 1998; McCarn & Fassinger, 1996; Morris, 1997; Ponticelli, 1999; Wolkomir, 2001).

Given this new understanding of sexual orientation and sexual orientation identity, a great deal of debate surrounds the question of how best to assess sexual orientation in research (Gonsiorek et al., 1995; Kinsey et al., 1948, 1953; Masters & Johnson, 1979; Sell, 1997). For example, some authors have criticized the Kinsey scale for dichotomizing sexual orientation—with heterosexuality and homosexuality as opposites along a single dimension and bisexuality in between—thus implying that in increasing desire for one sex represents reduced desire for the other sex (Gonsiorek et al., 1995; Sell, 1997; R. L. Worthington, 2003; R. L. Worthington & Reynolds, 2009). An alternative that has been proposed suggests that same-sex and other-sex attractions and desires may coexist relatively independently and may not be mutually exclusive (Diamond, 2003, 2006; 2008; Fox, 2004; Klein et al., 1985,[31] Sell, 1997; Shively & DeCecco, 1977; Storms,

[31] Although Klein advanced the notion of sexual orientation as a multidimensional variable, his Sexual Orientation Grid confounds constructs of sexual orientation and sexual orientation identity, as it includes attraction; behavior; identification; and emotional, political, and social preferences.

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

Considered in the context of the conceptual complexities of and debates over the assessment of sexual orientation, much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals. Early research that focuses on sexual arousal may be more precise than that which relies on self-report of behavior. Overall, recent research may actually measure sexual orientation identity (i.e., beliefs about sexual orientation, self-report of identity or group affiliation, self-report of behavior, and self-labeling) rather than sexual orientation.

Much of the SOCE research does not adequately define the construct of sexual orientation, does not differentiate it from sexual orientation identity, or has misleading definitions that do not accurately assess or acknowledge bisexual individuals.

Study treatments

In general, what constitutes SOCE in empirical research is quite varied. As we show in Appendix B, early studies tested a variety of interventions that include aversive conditioning techniques (e.g., electric shock, deprivation of food and liquids, smelling salts, chemically induced nausea), biofeedback, hypnosis, masturbation reconditioning, psychotherapy, systematic desensitization, and combinations of these approaches. A small number of early studies compare approaches alone or in combination. The more recent research includes an even wider variety of interventions (e.g., gender role reconditioning, support groups, prayer, psychotherapy) and providers (e.g., licensed and unlicensed LMHP in varied disciplines, pastoral counselors, laypersons). The recent studies were conducted in such a way that it is not possible to attribute results to any particular intervention component, approach, or provider. For instance, these interventions were provided simultaneously or sequentially, without specific separate evaluations of each intervention. The recent research and much of the early research cannot provide clarity regarding which specific efforts are associated with which specific outcomes.

Outcome measures

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

In recent research on SOCE, overreliance on self-report measures and/or on measures of unknown validity and reliability is common. Reliance on self-reports is especially vulnerable to a variety of reactivity biases such that shifts in an individual's score will reflect factors other than true change. Some of these biases are related to individual motivations, which have already been discussed, and others are

due to features of the experimental situation. Knowing that one is being studied and what the experimenter hopes to find can heighten people's tendency to self-report in socially desirable ways and in ways that please the experimenter.

Measures used in early studies vary tremendously in their psychometric acceptability, particularly for attitudinal and mental health measures, with a limited number of studies using well-validated measures. Recent research has not advanced significantly in using psychometrically sound measures of important study variables such as depression, despite the widespread use of measures that permit accurate assessment of these variables in other studies. Measures in these studies are also sources of bias due to problems such as item wording and response anchors from which participants may have inferred that other-sex attraction is a normative standard, as well as from the exclusion of items related to healthy homosexual functioning to parallel items that ask for reports on healthy heterosexual functioning.

Study operations

Regarding the adequacy of study operations, few of the early studies attempted to overcome the demand characteristics associated with the interventionists, obtaining measures of change themselves. In other words, few studies sought to minimize the possibility that people receiving treatment would be motivated to please their treatment providers by providing them with reports that were consistent with what the providers were perceived to desire and expect. Issues in recruitment of participants may also contribute to this effect; subjects were aware of the goals of the study, were recruited by individuals with that knowledge, or were participating in treatment to avoid legal and/or religious sanction. Novelty effects associated with exposure to an experimental laboratory situation may also have influenced study results. People may become excited and energized by participating in a research investigation, and these reactions to being in the research environment may contribute to change in scores. Recent research is also vulnerable to demand characteristics as a function of how individuals are recruited into samples, which is discussed in more detail in the section on sampling concerns.

CONCLUSION VALIDITY CONCERNS

Conclusion validity concerns the validity of the inferences about the presence or absence of a relationship among variables that are drawn from statistical tests. Small sample sizes, sample heterogeneity, weak measures, and violations to the assumptions of statistical tests (e.g., non-normally distributed data) are central threats to drawing valid conclusions. In this body of research, conclusion validity is often severely compromised. Many of the studies from the early period are characterized by samples that are very small, containing on the average about 9 subjects (see Appendix B; see also H. E. Adams & Sturgis, 1977). Coupled with high rates of attrition, skewed distributions, unreliable measures, and infrequent use of statistical tests designed for small and skewed samples, confidence in the statistical results of many of these studies may be misplaced. The recent research involved unreliable measures and inappropriate selection and performance of statistical tests, which are threats to their statistical conclusion validity,[32] even though these studies involved larger samples than the early research.

Problems in Generalizing Findings

A significant challenge to interpreting the research on SOCE is establishing external validity—that is, judging to whom and to what circumstances the results of any particular study might reasonably be generalized.

[32] For instance, to assess whether sexual orientation had changed, Nicolosi et al. (2000) performed a chi-square test of association on individuals' prior and current self-rated sexual orientation. Several features of the analysis are problematic. Specifically, the nature of the data and research question are inappropriate to a chi-square test of association, and it does not appear that the tests were properly performed. Chi-square tests of association assume that data are independent, yet these data are not independent because the row and column scores represent an individual's rating of his or her past and present self. Chi-square tests ought not to be performed if a cell in the contingency table includes fewer than five cases. Other tests, such as the nonparametric McNemar's test for dichotomous variables (McNemar, 1969) or the sign (Conover, 1980) or Wilcoxon signed-rank tests (Wilcoxon, 1945) for nominal and ordinal data, respectively, are used to assess whether there are significant differences between an individual's before and after score and are appropriate when data fail to meet the assumptions of independence and normality, as these data do and would have been more appropriate choices. Paired *t*-tests for mean differences could also have been performed on these data. There are procedural problems in performing the chi-square test such as missing data, and the analyses are conducted without adjustment for chance, with different numbers of subjects responding to each item, and without corrections to the gain scores to address regression artifacts. Taken together, however, the problems associated with running so many tests without adjusting for chance associations or correcting for regression artifacts and having different respondents in nearly every test make it difficult to assess what changes in scores across these items actually reflect.

SAMPLE COMPOSITION

Concerns regarding the sample composition in these studies are common in critiques (e.g., Cramer et al., 2008). The studies from the early period are characterized by samples that are narrow in their demographic characteristics, composed almost exclusively of Caucasian males over the age of 18. No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples. Few SOCE studies in the early period include women. Although more recent research includes women and respondents of diverse ethnic and racial backgrounds (e.g., Moran, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001), White men continue to dominate recent study samples. Thus, the research findings from early and recent studies may have limited applicability to non-Whites, youth, or women. The samples in the recent research have been narrowly defined in other respects, focusing on well-educated, middle-class individuals to whom religion is extremely important (e.g., Beckstead & Morrow, 2004; Nicolosi et al, 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003; Wolkomir, 2001). Same-sex sexual attraction and treatments are confounded with these particular demographic characteristics across the recent literature. These research findings may be most applicable to educated White men who consider themselves highly religious.

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

The early research sometimes included men who were receiving intervention involuntarily (e.g., Barlow, Agras, Abel, Blanchard, & Young, 1975; Callahan & Leitenberg, 1973; S. James, 1978; MacCulloch & Feldman, 1967; MacCulloch et al., 1965; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972), usually men who were court referred as a result of convictions on charges related to criminalized acts of homosexual sex.[33] The samples also include men who were not receiving intervention because of same-sex sexual attractions; rather, some of the men receiving intervention are described as pedophiles, exhibitionists, transvestites, and fetishists (Callahan & Leitenberg, 1973; Conrad & Wincze, 1976; Fookes, 1960; Hallam & Rachman, 1972; Marquis, 1970; Thorpe, Schmidt, Brown, & Castell, 1964; Thorpe, Schmidt, & Castell, 1963). Thus, the early samples are notable for including men who may not be same-sex attracted at all or who may not be distressed by their attractions but who had to undergo intervention by court order or out of fear of being caught by law enforcement in the future.

Moreover, in the early research—to the extent that it was assessed—the samples contained individuals who varied widely along the spectrum of same-sex sexual orientation prior to intervention, so that the studies included men who were other-sex sexually attracted to varying degrees alongside men who were primarily or exclusively same-sex sexually attracted (Bancroft, 1969; Barlow et al., 1975; Birk, 1974; Conrad & Wincze, 1976; Fookes, 1960; Hallman & Rachman, 1972; Kendrick & MacCulloch, 1972; LoPiccolo, Stewart, & Watkins, 1972; Marquis, 1970; McCrady, 1973). Additionally, study samples included men with and without histories of current and prior sexual contact with men and women (Bancroft, 1969; Colson, 1972; Curtis & Presly, 1972; Fookes, 1960; Freeman & Meyer, 1975; Gray, 1970; Hallman & Rachman, 1972; Herman, Barlow, & Agras, 1974; Larson, 1970; Levin, Hirsch, Shugar, & Kapche, 1968; LoPiccolo et al., 1972; MacCulloch & Feldman, 1967; McConaghy, 1969; McConaghy et al., 1972, 1981; McConaghy & Barr, 1973; Segal & Sims, 1972; Thorpe et al., 1964), so that men who are or have been sexually active with women and men, only women, only men, or neither are combined. Some recent studies of SOCE have similar problems (e.g., Spitzer, 2003). Including participants with attractions, sexual arousal, and behaviors to both sexes in the research on SOCE makes evaluating change more difficult (Diamond, 2003; Rust, 2003; Vasey & Rendell, 2003; R. L. Worthington, 2003).

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

Data analyses rarely adjust for preintervention factors such as voluntary pursuit of intervention, initial degree of other-sex attraction, or past and current other-sex and same-sex behaviors; in very few studies did investigators perform and report subgroup analyses to clarify how subpopulations fared as a result of intervention. The absence of these analyses obscure results for men who are primarily same-sex attracted and seeking intervention regarding these attractions versus any other group of men in these studies, such as men who could be characterized as bisexual in their attractions and behaviors or those on whom treatment

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

was imposed. For these reasons, the external validity (generalizability) of the early studies is unclear, with selection-treatment interactions of particular concern. It is uncertain which effects observed in these studies would hold for which groups of same-sex attracted people.

SAMPLING AND RECRUITMENT PROCEDURES

Early and recent study samples are typically of convenience, so it is unclear precisely what populations these samples represent. Respondents in the recent studies are typically recruited through ex-gay ministries and advocates of SOCE rather than through population-based probability sampling strategies designed to obtain a representative sample of same-sex attracted people or the subset of them who experience their attractions as distressing and have sought and been exposed to SOCE. Additionally, study respondents are often invited to participate in these studies by LMHP who are proponents of SOCE, introducing unknown selection biases into the recruitment process (cf. Beckstead, 2003; Shidlo & Schroeder, 2002).

Qualitative studies have been more successful in applying a variety of purposive stratified sampling strategies (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and developing appropriate comparison samples. However, the qualitative studies were not undertaken with the purpose of determining if SOCE interventions are effective in changing sexual orientation. These studies focused on understanding aspects of the experience of participating in SOCE from the perspective of same-sex attracted people in distress.

As noted previously, recent research has used designs that are incapable of making attributions of intervention effects. In many of the recent studies, the nature of the procedures for recruiting samples is likely to have accentuated response-shift biases rather than to have minimized them, because study recruiters were open proponents of the techniques under scrutiny; it cannot be assumed that the recruiters sought to encourage the participation of those individuals whose experiences ran counter to their own view of the value of these approaches. Proponents of these efforts may also have limited access to the research for former clients who were perceived to have failed the intervention or who experienced it as harmful. Some of the recent research to assess harm resulting from these interventions (Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002) suffers from sampling weaknesses and biases of a similar nature.

Treatment Environments

Clinically trained professionals using reasonably well-described change efforts generally conducted early research in clinical laboratory settings. By contrast, the recent research included a wide variety of change efforts, providers, and settings in which these efforts may take place. The recent research has not been performed in a manner that permits examination of the interactions among characteristics of change efforts, providers, settings, and individuals seeking to change, nor does the research associate these patterns with outcomes.

Summary

Our analysis of the methodology of SOCE reveals substantial deficiencies. These deficiencies include limitations in making causal claims due to threats to internal validity (such as sample attrition, use of retrospective pretests, lack of construct validity including definition and assessment of sexual orientation, and variability of study treatments and outcome measures). Additional limitations with recent research include problems with conclusion validity (the ability to make inferences from the data) due to small or skewed samples, unreliable measures, and inappropriate selection and performance of statistical tests. Due to these limitations, the recent empirical literature provides little basis for concluding whether SOCE has any effect on sexual orientation. Any reading of the literature on SOCE outcomes must take into account the limited generalizability of the study samples to the population of people who experience same-sex sexual attraction and are distressed by it. Taking into account the weaknesses and limitations of the evidence base, we next summarize the results from research in which same-sex sexual attraction and behavior have been treated.

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

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

In Chapter 3, we provided an overview of our systematic review of research on sexual orientation change efforts[34] (SOCE) and the results of the review for methodological concerns. In this chapter, we describe the evidence on outcomes associated with SOCE, whether beneficial or harmful. No studies reported effect size estimates or confidence intervals, and many studies did not report all of the information that would be required to compute effect sizes. As a result, statistical significance and methodology are considered in interpreting the importance of the findings. As the report will show, the peer-refereed empirical research on the outcomes of efforts to alter sexual orientation provides little evidence of efficacy and some evidence of harm. We first summarize the evidence of efficacy and then the evidence of unintended harmful effects.

Reports of Benefit

Sexual orientation change efforts have aimed to address distress in individuals with same-sex sexual attractions by achieving a variety of different outcomes:

- Decreased interest in, sexual attraction to, and sexual behavior with same-sex sexual partners
- Increased interest in, sexual attraction to, and sexual behavior with other-sex sexual partners
- Increased healthy relationships and marriages with other-sex partners
- Improved quality of life and mental health

Although not all of these aims are equally well studied, these are the outcomes that have been studied frequently enough to be reported in this systematic review. One general point that we wish to emphasize as we begin the discussion of the outcomes that have been reported in this literature is that nonexperimental studies often find positive effects that do not hold up under the rigor of experimentation. The literature on SOCE is generally consistent with this point. In other words, the least rigorous studies in this body of research generally provide a more positive assessment of efficacy than do studies that meet even the most minimal standards of scientific rigor.

Decreasing Same-Sex Sexual Attraction

EARLY STUDIES

A number of investigators have assessed aversion therapy interventions to reduce physiological and self-reported sexual arousal in response to same-sex stimuli and self-reports of same-sex sexual attraction (see Appendix B).

[34] In this report, we use the term *sexual orientation change efforts* (SOCE) to describe a method that aims to change a same-sex sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

Experimental studies

Results from the experimental studies of aversive techniques provide some evidence that these treatments can reduce self-reported and physiological sexual arousal for some men. The experimental studies that we reviewed showed lower rates of change in sexual arousal toward the same sex than did the quasi-experimental and nonexperimental studies. This finding was consistent with H. E. Adams and Sturgis's (1977) review of studies published through 1976.

In their review, H. E. Adams and Sturgis (1977) found that across the seven studies that they classified as controlled studies, 34% of the 179 subjects that were retained in these studies decreased their same-sex sexual arousal. McConaghy (1976) found that roughly half of the men who received one of four treatment regimens reported less intense sexual interest in men at 6 months. McConaghy, Proctor, and Barr (1972) found reductions in penile response in the laboratory following treatment. However, penile response to female nudes also declined for those men who initially responded to female stimuli. McConaghy (1969) similarly reported a decline in sexual arousal to all stimuli as a result of treatment for some men and that treatment also increased same-sex sexual arousal for some men. Overall, however, a majority of participants showed decreases in same-sex sexual arousal immediately following treatment. McConaghy and Barr (1973) found that about half of men reported that their same-sex sexual attractions were reduced. Tanner (1975) found that aversive shock could lessen erectile response to male stimuli.

An important caveat in considering the results of these experiments is that none compared treatment outcomes to an untreated control group. That is, these studies compared treatments to one another. The fact that four of these studies also involved men who were being treated by court referral should also be considered in interpreting the findings. These experiments cannot address whether men would have changed their sexual arousal pattern in the absence of treatment. Only one of the experiments that we identified compared treatment outcomes against the outcomes for an untreated control group. Tanner (1974) examined change in sexual arousal among 8 men receiving electric shock therapy. Tanner found that physiological arousal to male stimuli in the laboratory had declined at the 8-week follow-up, when scores among the 8 men in the treatment were compared with those of the 8 men in a control group. Changes were not achieved for all of the men, and there were no differences between the experimental and control groups in the frequency of same-sex sexual behavior.

The results of the experimental studies suggest that some men who participate in clinical treatment studies may be conditioned to control their sexual arousal response to sexual stimuli, although McConaghy's (cf. McConaghy, 1999) studies suggest that aversive treatments may affect sexual arousal indiscriminately. These studies found that not all men reduce their sexual arousal to these treatments and that changes in sexual arousal in the lab are not necessarily associated with change in sexual behavior.

Quasi-experimental studies

The three quasi-experiments listed in Appendix B all compare treatment alternatives for nonequivalent groups of men. Birk et al. (1971) found that 5 (62%) of the 8 men in the aversive treatment condition reported decreased sexual feelings following treatment; one man out of the 8 (12%) demonstrated reduced sexual arousal at long-term follow-up. In comparing groups, the researchers found that reports of same-sex "cruising," same-sex sexual "petting," and orgasm declined significantly for men receiving shocks when compared with men receiving associative conditioning. McConaghy and colleagues (1981) found that 50% of respondents reported decreased sexual feelings at 1 year. S. James (1978) reported that anticipatory avoidance learning was relatively ineffective when compared with desensitization. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they termed uncontrolled studies reported reduced sexual arousal.

Nonexperimental studies

Nonexperimental studies, which lack sufficient rigor to assess efficacy but which may be useful in identifying potential treatment approaches, offer a similar view of the impact of aversive treatment on reductions in sexual arousal. For instance, Bancroft (1969), in a within-subject study without a comparison group, delivered electric shocks based on males' penile volume response to photographs of nude men as they were fantasizing about homosexual sexual encounters. Research subjects underwent a minimum of 30 treatment sessions. Bancroft reported that of the men who were initially sexually attracted to both sexes, 30% (n = 3) of these men lessened their same-sex sexual interest over the long-term. Among those with no initial other-sex sexual attraction, no lasting changes were observed in sexual

arousal and attraction. Several other uncontrolled studies found reductions in participants' self-reported sexual attraction and physiological response under laboratory conditions (range = 7%–100%; average = 58%) (Callahan & Leitenberg, 1973; Feldman & MacCulloch, 1965; Fookes, 1960; Hallan & Rachman, 1972; MacCulloch & Feldman, 1967; Sandford, Tustin, & Priest, 1975).

As is typically found in intervention research, the average proportion of men who are reported to change in uncontrolled studies is roughly double the average proportion of men who are reported to change in controlled studies. For instance, as noted previously, results from controlled studies show that far less change can be produced in same-sex sexual arousal by aversion techniques. H.E. Adams and Sturgis (1977) reported that in the nonexperimental studies in their review, 68% of 47 participants reduced their same-sex sexual arousal, as compared with 34% of participants in experimental studies.

The studies of nonaversive techniques as the primary treatment, such as biofeedback and hypnosis, were only assessed in the nonexperimental within-subject and patient case studies. For example, Blitch and Haynes (1972) treated a single female who was heterosexually experienced and whom they described as strongly committed to reducing her same-sex sexual attractions. Using relaxation, rehearsal, and masturbation reconditioning, she was reported to be able to masturbate without female fantasies 2 months after intervention. Curtis and Presly (1972) used covert sensitization to treat a married man who experienced guilt about his attraction to and extramarital engagement with men. After intervention, he showed reduced other-sex and same-sex sexual interest, as measured by questionnaire items. Huff (1970) treated a single male who was interested in becoming sexually attracted to women. Following desensitization, his journal entries showed that his same-sex sexual fantasies continued, though the ratio of other-sex to same-sex sexual fantasies changed by the 6-month follow-up to favor other-sex sexual fantasies. His MMPI scores showed improvement in his self-concept and reductions in his distress.

By contrast, among the 4 men exposed to orgasmic reconditioning by Conrad and Wincze (1976), all reported decreased same-sex sexual attractions immediately following intervention, but only one demonstrated a short-term measurable alteration in physiological responses to male stimuli. Indeed, one subject's sexual arousal to same-sex sexual stimuli increased rather than decreased, a result that was obtained for some men in the experimental studies. In a study by Barlow and colleagues (1975), among 3 men who were each exposed to unique biofeedback treatment regimens, all maintained same-sex sexual arousal patterns at follow-up, as measured by penile circumference change in response to photos of male stimuli.

Mintz (1966) found that 8 years after initiating group and individual therapy, 5 of his 10 research participants (50%) had dropped out of therapy. Mintz perceived that among those who remained, 20% (n = 1) were distressed, 40% (n = 2) accepted their same-sex sexual attractions, and 40% (n = 2) were free from conflict regarding same-sex sexual attractions. Birk (1974) assessed the impact of behavioral therapy on 66 men, of whom 60% (n = 40) had dropped out of intervention by 7 months. Among those who remained in the study, a majority shifted toward heterosexual scores on the Kinsey scale by 18 months.

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

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

RECENT STUDIES

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

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

SUMMARY

Overall, early studies suggest that modest short-term effects on reducing same-sex sexual arousal in the laboratory may be obtained for a minority of study participants through some forms of SOCE, principally interventions involving aversion procedures such as electric shock. Short-term reductions in sexual arousal to other-sex stimuli were also reported for some treatments. When outcomes were described for individual participants or subgroups of participants, short-term reductions in same-sex sexual arousal patterns were more commonly reported for people described as having other-sex sexual attractions prior to intervention and high levels of motivation to change. Initial and sustained reductions in sexual arousal were reported less commonly for people who were described as having no other-sex sexual attraction prior to intervention. The results from the uncontrolled studies are more positive than those from the controlled studies, as would be expected. Yet these studies also found that reduction in sexual arousal may not occur for study participants. Recent studies provide no sound scientific basis for determining the impact of SOCE on decreasing same-sex sexual attraction.

Decreasing Same-Sex Sexual Behavior

EARLY STUDIES

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

Experimental studies

In their review, H. E. Adams and Sturgis (1977) found that across the seven controlled studies published between 1960 and 1976, 18% of 179 subjects in these studies were reported to have decreased same-sex sexual behavior; the percentage reporting reductions in sexual arousal was nearly double that percentage, at 34%. In our review, we found that the results of the experimental studies that we reviewed provided a picture of the effects of aversive forms of SOCE similar to that painted by H. E. Adams & Sturgis.

For instance, in his study comparing aversion and aversion relief therapies,[36] McConaghy (1969) reported that about 20% of men had engaged in same-sex sexual behavior within 2 weeks following treatment. No longer term data are reported. McConaghy (1976) found that 50% of men had reduced the frequency of their same-sex behavior, 25% had not changed their same-sex behavior, and 25% reported no same-sex behavior at 1 year. McConaghy and Barr (1973) reported that 25% of men had reduced their same-sex sexual behavior at 1-year. Tanner (1975) reported a significant decline in same-sex behavior across treatments. In the only untreated control group study that we identified, Tanner (1974) found that intervention had no effect on rates of same-sex behavior, even though the intervention did reduce changes in penile circumference in response to male stimuli in the lab.

Quasi-experimental studies

Birk and colleagues (1971) found that 2 of 18 men (11%) had avoided same-sex behavior at 36 months. McConaghy, Armstrong, and Blaszczynski (1981) reported that among the 11 men who were sexually active with same-sex partners, about 25% reduced their same-sex behavior. S. James (1978) did not report on behavior. In their review, H. E. Adams and Sturgis (1977) found that 50% of the 124 participants in what they called uncontrolled group studies reported reduced sexual arousal, and 42% reported less frequent same-sex sexual behavior. Among the quasi-experiments that we reviewed, the reported reductions in sexual behavior were lower (i.e., 11% and 25%) than what was reported by Adams and Sturgis. These differences may be due to our more rigorous criteria of what constitutes a quasi-experiment than the criteria employed by Adams and Sturgis.

Nonexperimental studies

Among the case and single-group within-subject studies, the results are mixed. Some studies found that people reported having abstained from same-sex behavior in the months immediately following intervention or having decreased its frequency. Bancroft (1969) found that 4 of the 10 men in his study had reduced their behavior at follow-up. Freeman and Meyer (1975) found that 7 of the 9 men in their study were abstinent at 18

[35] In considering the results of early studies on this outcome, readers are advised that data on this outcome are not always reported. In some cases, not all research participants in these studies had engaged in sexual activity with same-sex partners prior to treatment, though they may have fantasized about doing so. In other studies, reducing sexual arousal under lab conditions was examined and not behavior in daily life.

[36] Aversive therapy is the application of a painful stimuli; aversion relief therapy is the cessation of an aversive stimulus.

months. Other single-subject and case study subjects reported declines in or no same-sex behavior (Gray, 1970; Huff, 1970; B. James, 1962, 1963; Kendrick & McCullough, 1972; Larson, 1970; LoPiccolo, 1971; Segal & Sims, 1972).

Not all individuals, however, successfully abstained on every occasion of sexual opportunity (Colson, 1972; Rehm & Rozensky, 1974), and some relapse occurred within months following treatment (Bancroft, 1969; Freeman & Meyer, 1975; Hallam & Rachman, 1972; Levin et al., 1968; MacCulloch et al., 1965; Marquis, 1970). In other studies, the proportion reporting that they changed their sexual behavior is a minority. For instance, among Barlow et al.'s (1975) research participants, 2 of the 3 men demonstrated no change in their same-sex behavior. In the case studies, clients who were described as exclusively attracted to the same sex prior to treatment were most commonly reported to have failed to avoid same-sex sexual behavior following treatment.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current behavior to SOCE. No results are reported for these studies.

SUMMARY

In the early studies with the greatest rigor, it appears that SOCE may have decreased short-term same-sex sexual behavior for a minority of men. However, in the only randomized control group trial, the intervention had no effect on same-sex sexual behavior. Quasi-experimental results found that a minority of men reported reductions in same-sex sexual behavior following SOCE. The nonexperimental studies found that study participants often reported reduced behavior but also found that reductions in same-sex sexual behavior, when reported, were not always sustained.

Increasing Other-Sex Sexual Attraction

Early studies provide limited evidence for reductions in sexual arousal to same-sex stimuli and for reductions in same-sex sexual behavior following aversive treatments. The impact of the use of aversive treatments for increasing other-sex sexual arousal is negligible.

EARLY STUDIES

Experimental studies

In many of the early experiments on aversive treatments, sexual arousal to female sexual stimuli was a desired outcome. McConaghy (1969) found that about 16% of 40 men increased their sexual arousal to female stimuli immediately following treatment and that 5% increased their sexual arousal to male stimuli. It is unclear how the 50% of men in this study who were aroused by females prior to the treatment were distributed among the men who increased their sexual arousal and among those who did not. In other words, it is possible that most of the men who changed were sexually aroused by women initially. In interviews following treatment, McConaghy (1976) reported that 25% of 157 men indicated that they felt more sexual arousal toward females than they did before treatment. McConaghy, Proctor, and Barr (1972) found no change in rates of sexual arousal to female stimuli. McConaghy et al.'s (1972) research participants showed no change in penile volume in response to female stimuli after intervention.

In a randomized control trial, Tanner's (1974) 8 research participants reported increases in sexual fantasizing about other-sex partners after aversive conditioning. However, penile circumference data showed no increased sexual arousal to female stimuli. H. E. Adams and Sturgis (1977) found that 26% of 179 participants in the controlled studies that they reviewed increased their sexual arousal toward the other-sex.

Quasi-experimental studies

Birk and colleagues (1971) found no difference between their treatment groups in reported sexual arousal to women. Two men (11% of 18 participants) in the study reported sustained sexual interest in women following treatment. McConaghy and colleagues (1981) reported no significant improvement in attraction to females. S. James (1978) reported little impact of treatment on participants in anticipatory avoidance learning. He noted a general improvement among 80% of the 40 men undergoing desensitization to other-sex situations.

Nonexperimental studies

Among the nonexperimental studies, for men who were described as having some degree of other-sex sexual attraction and experience before the intervention, the balance of studies showed an increase in other-sex sexual attraction over time, although given the

nonexperimental nature of these studies, this change cannot be validly attributed to SOCE. For men with little or no preintervention other-sex sexual attraction, the research provides little evidence of increased other-sex sexual attraction.

As in some of the experimental studies, the results reported in the nonexperiments were not always in the desired direction. Studies occasionally showed that reductions in sexual arousal and interest may occur for same- and other-sex partners, suggesting the possibility that treatments may lower sexual arousal to sexual stimuli in general. For instance, Curtis and Presly's (1972) married male subject reported slightly lower rates of sexual arousal in response to women than before intervention, in addition to reduced same-sex sexual arousal.

Among early studies, many found little or no increases in other-sex sexual attraction among participants who showed limited or no other-sex sexual attraction to begin with. For instance, 2 of the 3 men in Barlow et al.'s (1975) within-subject biofeedback investigation reported little or no other-sex sexual interest prior to intervention. As measured by penile circumference, one of these men demonstrated negligible increases in other-sex sexual attraction; one other individual showed stable low other-sex sexual attraction, which contradicted his self-report.

In contrast, a handful of the early single-patient case studies found increases in other-sex attraction. For instance, Hanson and Adesso's (1972) research participant, who was reported to be primarily same-sex sexually attracted at the onset of intervention, increased his sexual arousal to women and ultimately reported that he enjoyed sex with women. Huff's (1970) male research participant also reported increased other-sex sexual attraction at 6 months following desensitization.

RECENT STUDIES

As we have noted, recent studies provide no sound basis for attributing individual reports of their current other-sex sexual attraction to SOCE. No results are reported for these studies.

SUMMARY

Taken together, the research provides little support for the ability of interventions to develop other-sex sexual attraction where it did not previously exist, though it may be possible to accentuate other-sex sexual attraction among those who already experience it.

Increasing Other-Sex Sexual Behavior

Studies on whether interventions can lead to other-sex sexual activity show limited results. These studies show more success for those who had an other-sex sexual orientation (e.g., sexual arousal) and were sexually experienced with members of the other sex prior to intervention than for those who had no other-sex sexual orientation and no history of other-sex sexual behavior. The results for this outcome suggest that some people can initiate other-sex sexual behavior whether or not they have any observed other-sex sexual orientation.

As previously noted, in the early studies many people were described as heterosexually experienced. From the data provided by H.E. Adam and Sturgis in their 1977 review, 61%–80% of male research participants appeared to have histories of dating women, and 33%–63% had sexual intercourse with women prior to intervention. Additionally, some of the men were married at the time of intervention. Because so many of the research participants in these studies had other-sex sexual attractions or intimate relationships at the outset, it is unclear how to interpret changes in their levels of other-sex sexual activity.

EARLY STUDIES

Experimental studies

According to H. E. Adams and Sturgis (1977), only 8% of participants in controlled studies are reported to have engaged in other-sex sexual behavior following SOCE. Among those studies we reviewed, only 2 participants showed a significant increase in other-sex sexual activity (McConaghy & Barr, 1973; Tanner, 1974). In Tanner's randomized controlled trial, men increased the frequency of intercourse with females but maintained the frequency of intercourse with males.

Quasi-experimental studies

McConaghy et al. (1981) found no difference in the frequency of other-sex sexual behavior following SOCE.

Nonexperimental studies

Among within-subject patient studies in which aversion techniques were used, some studies reported that a subset of 12%–40% of people in the multiple-subject studies and all people in single-patient studies engaged in other-sex sexual behavior following intervention (e.g., Bancroft, 1969; Fookes, 1960; Hallam & Rachman, 1972; Hanson & Adesso, 1972; Kendrick & McCullough, 1972; Larson, 1970). Regarding other techniques

studied in early intervention research, Barlow et al. (1975) reported that 1 of 3 research participants began to date women after biofeedback. Huff's (1970) research participant also began to date women after desensitization training. LoPiccolo (1971) used orgasmic reconditioning to treat a male–female couple. The male could not achieve an erection with his female partner and found sex with women dissatisfying. At 6 months, he was able to develop and maintain an erection and ejaculate intravaginally.

RECENT STUDIES

As previously noted, recent studies provide no sound basis for attributing individual reports of their current sexual behavior to SOCE. No results are reported for these studies.

SUMMARY

In general, the results from studies indicate that while some people who undergo SOCE do engage in other-sex sexual behavior afterward, the balance of the evidence suggests that SOCE is unlikely to increase other-sex sexual behavior. Findings show that the likelihood of having sex with other-sex partners for those research participants who possess no other-sex sexual orientation prior to the intervention is low.

Marriage

One outcome that some proponents of efforts to change sexual orientation are reported to value is entry into heterosexual marriage. Few early studies reported on whether people became heterosexually married after intervention. In a quasi-experimental study, Birk et al. (1971) found that 2 of 18 respondents (11%) were married at 36 months. Two uncontrolled studies (Birk, 1974; Larson, 1970) indicated that a minority of research participants ultimately married, though it is not clear what role, if any, intervention played in this outcome. Recent research provides more information on marriage, though research designs do not permit any attribution of marital outcomes to SOCE.

Improving Mental Health

The relationship between mental health, psychological well-being, sexual orientation, sexual orientation identity, and sexual behavior is important. Few studies report health and mental health outcomes, and those that do report outcomes tend to use psychometrically weak measures of these constructs and weak study designs. Among the early studies that report on mental health, three nonexperimental single-patient case studies report that clients were more self-assured (Blitch & Haynes, 1972) or less fearful and distressed (Hanson & Adesso, 1972; Huff, 1970).

Overall, the lack of high-quality data on mental health outcomes of efforts to change sexual orientation provide no sound basis for claims that people's mental health and quality of life improve. Indeed, these studies add little to understanding how SOCE affects people's long-term mental health.

Reports of Harm

Determining the efficacy of any intervention includes examination of its side effects and evidence of its harm (Flay et al., 2005; Lilienfeld, 2007). A central issue in the debates regarding efforts to change same-sex sexual attractions concerns the risk of harm to people that may result from attempts to change their sexual orientation. Here we consider evidence of harm in early and recent research.

EARLY STUDIES

Early research on efforts to change sexual orientation focused heavily on interventions that include aversion techniques. Many of these studies did not set out to investigate harm. Nonetheless, these studies provide some suggestion that harm can occur from aversive efforts to change sexual orientation.

EXPERIMENTAL STUDIES

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

QUASI-EXPERIMENTAL STUDIES

None reported on adverse events.

NONEXPERIMENTAL STUDIES

A majority of the reports on iatrogenic effects are provided in the nonexperimental studies. In the study conducted by Bancroft (1969), the negative outcomes reported include treatment-related anxiety (20% of 16

participants), suicidal ideation (10% of 16 participants), depression (40% of 16 participants), impotence (10% of 16 participants), and relationship dysfunction (10% of 16 participants). Overall, Bancroft reported the intervention had harmful effects on 50% of the 16 research subjects who were exposed to it. Quinn, Harrison, and McAllister (1970) and Thorpe et al. (1964) also reported cases of debilitating depression, gastric distress, nightmares, and anxiety. Herman and Prewett (1974) reported that following treatment, their research participant began to engage in abusive use of alcohol that required his rehospitalization. It is unclear to what extent and how his treatment failure may have contributed to his abusive drinking. B. James (1962) reported symptoms of severe dehydration (acetonuria), which forced treatment to be suspended. Overall, although most early research provides little information on how research participants fared over the longer term and whether interventions were associated with long-term negative effects, negative effects of treatment are reported to have occurred for some people during and immediately following treatment.

High dropout rates characterize early treatment studies and may be an indicator that research participants experience these treatments as harmful. Lilienfeld's (2007) review of harm in psychotherapy identifies dropout as not only an indicator of direct harm but also of treatment ineffectiveness.

RECENT STUDIES

Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Smith et al., 2004), just as other recent studies document that there are people who perceive that they have benefited from it (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Pattison & Pattison, 1980; Schaeffer et al., 2000; Spitzer, 2003). Among those studies reporting on the perceptions of harm, the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction. These reports of perceptions of harm are countered by accounts of perceptions of relief, happiness, improved relationships with God, and perceived improvement in mental health status, among other reported benefits. Many participants in studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described experiencing first the positive effects and then experiencing or acknowledging the negative effects later.

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

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE. However, studies from both periods indicate that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts. The lack of rigorous research on the safety of SOCE represents a serious concern, as do studies that report perceptions of harm (cf. Lilienfeld, 2007).

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

Conclusion

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

enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed any credible evidence of reduced same-sex sexual attraction, though some show lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and increased attraction to and engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

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

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

5. RESEARCH ON ADULTS WHO UNDERGO SEXUAL ORIENTATION CHANGE EFFORTS

In the three chapters preceding this one, we have focused on sexual orientation change efforts[37] (SOCE), because such interventions have been the primary focus of attention and contention in recent decades. Now we turn from the problem of sexual orientation change, as it has been defined by "expert" narratives of sin, crime, disorder, and dysfunction in previous chapters, to the problem of sexual orientation distress, as it exists in the lives of individuals who seek sexual orientation change. We try to present what the research literature reveals—and clarify what it does not—about the natural history of the phenomenon of people who present to LMHP seeking SOCE.

We do this for two major reasons. The first is to provide a scholarly basis for responding to the core task force charge: "the appropriate application of affirmative therapeutic interventions" for the population of those individuals who seek sexual orientation change. The second is our hope to step out of the polemic that has defined approaches to sexual orientation distress. As discussed in the introduction, some professional articles (e.g., Rosik, 2001, 2003; Yarhouse & Burkett, 2002), organizations, and accounts of polemical debates (cf. Drescher, 2003) have argued that APA and mainstream psychology are ignoring the needs of those for whom same-sex sexual attractions are unwanted, especially for religious populations. We hope that an empathic and comprehensive review of the scholarly literature of the population that seeks and participates in SOCE can facilitate an increased understanding of the needs of this population so that an affirmative therapeutic approach may be developed.

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We decided to expand our review beyond empirical literature to have a fuller view of the population in question. Because of the lack of empirical research in this area, the conclusions must be viewed as tentative. The studies that are included in this discussion are (a) surveys and studies of individuals who participated in SOCE and their perceptions of change, benefit, and harm (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton & Welton, 2005);[38] (b) high-quality qualitative studies of the concerns of participants and the dynamics of SOCE (e.g., Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); (c) case reports, clinical articles, dissertations, and reviews where sexual

[37] In this report, we use the term *sexual orientation change efforts* (SOCE) to describe a method that aims to change a same-sex sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

[38] As previously noted, these studies, due to their significant methodological issues, cannot assess whether actual sexual orientation change occurred.

orientation or sexual orientation identity change were considered or attempted (e.g., Borowich, 2008; Drescher, 1998a; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Karten, 2006; Mark, 2008; Tan, 2008; Yarhouse et al., 2005; Yarhouse, 2008); and (d) scholarly articles on the concerns of religious individuals who are conflicted by their same-sex sexual attractions, many of whom accept their same-sex sexual orientation (e.g., Coyle & Rafalin, 2000; Horlacher, 2006; Kerr, 1997; Mahaffy, 1996; Moran, 2007; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Smith et al., 2004; Thumma, 1991; Yip, 2000, 2002, 2003, 2005). We also reviewed a variety of additional scholarly articles on subtopics such as individuals in other-sex marriages and general literature on sexual orientation concerns.

Demographics

The majority of participants in research studies on SOCE have been Caucasian men. Early studies included some men who were court-referred (S. James, 1978; McConaghy, 1969, 1976; McConaghy et al., 1972) and whose participation was not voluntary, but more recent research primarily includes men who indicated that their religion is of central importance (Beckstead & Morrow, 2004; S. L. Jones & Yarhouse, 2007; Wolkomir, 2001). Some studies included small numbers of women (22%–29%; Nicolosi et al., 2000; S. L. Jones & Yarhouse, 2007; Schaeffer et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003), and two studies focused exclusively on women (Moran, 2007; Ponticelli, 1999). However, these studies do not examine if there are potential differences between the concerns of men and women. Members of racial-ethnic groups are not included in some samples (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001) and are a small percentage (5%–14%) of the sample in other studies (S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003). In the recent studies, no comparisons were reported between the ethnic minorities in the sample and others. Thus, there is no evidence that can elucidate concerns of ethnic minority individuals who have sought SOCE. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals who have sought SOCE.

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Samples in recent SOCE studies have been composed predominantly of individuals from conservative Christian denominations (Beckstead & Morrow, 2004; Erzen, 2006; Nicolosi et. al., 2000; Ponticelli, 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Spitzer, 2003; Wolkomir, 2001). These studies included very few nonreligious individuals, and the concerns of religious individuals of faiths other than Christian are not described. The published literature focused on the impact of religiously oriented self-help groups or was performed by those who sought referrals from groups that advocate SOCE. Thus, the existing literature limits information to the concerns of a particular group of religious individuals. Finally, most individuals in studies of SOCE have tried multiple ways to change their sexual orientation, ranging from individual psychotherapy to religiously oriented groups, over long periods of time and with varying degrees of satisfaction and varying perceptions of success (Beckstead & Morrow, 2004; Comstock, 1996; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Mark, 2008; Nicolosi et al., 2000; Shidlo & Schroeder, 2002).

Why Individuals Undergo SOCE

Because no research provides prevalence estimates of those participating in SOCE, we cannot determine how prevalent the wish to change sexual orientation is among the conservative Christian men who have predominated in the recent research, or among any other population. Clients' motivations to seek out and participate in SOCE seem to be complex and varied and may include mental health and personality issues, cultural concerns, religious faith, internalized stigma, as well as sexual orientation concerns (Beckstead & Morrow, 2004; Drescher, 1998a; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Lasser & Gottlieb, 2004; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000). Some of the factors influencing a client's request for SOCE that have been identified in the literature include the following:

- Confusion or questions about one's sexuality and sexual orientation (Beckstead & Morrow, 2004; Smith et al., 2004)

- Religious beliefs that consider homosexuality sinful or unacceptable (Erzen, 2006; Haldeman, 2004; S. L. Jones & Yarhouse, 2007; Mark, 2008; Ponticelli, 1999; Tan, 2008; Tozer & Hayes, 2004; Wolkomir, 2001, 2006; Yarhouse, 2008)
- Fear, stress, and anxiety surrounding the implications of an LGB identity (especially the illegitimacy of such an identity within the client's religious faith or community) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; Shidlo & Schroeder, 2002)
- Family pressure to be heterosexual and community rejection of those who are LGB (Haldeman, 2004; Glassgold, 2008; Mark, 2008; Shidlo & Schroeder, 2002; Smith et al., 2004)

Some individuals who have pursued SOCE report having had only unsuccessful or unfulfilling same-sex sexual experiences in venues such as bars or sexual "cruising" areas (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). These experiences reflected and re-created restricted views that the "gay lifestyle" is nonspiritual, sexually desperate, or addicted, depressive, diseased, and lonely (Drescher, 1998a; Green, 2003; Rosik, 2003; Scasta, 1998). Many sexual minority individuals who do not seek SOCE are also affected by these factors. Thus, these findings do not explain why some people seek SOCE and others do not.

There are some initial findings that suggest differences between those who seek SOCE and those who resolve their sexual minority stress through other means. For example, Ponticelli (1999) and S. L. Jones and Yarhouse (2007) reported higher levels of self-reported family violence and sexual abuse in their samples than were reported by Laumann et al. (1994) in a population-based sample. Beckstead and Morrow (2004) and S. L. Jones and Yarhouse reported high levels of parental rejection or authoritarianism among their religious samples (see also Smith et al., 2004). Wolkomir (2001) found that distress surrounding nonconformity to traditional gender roles distinguished the men in her sample who did not accept their sexual orientation from those who did. Similarly, Beckstead and Morrow found that distress and questions about masculinity were an important appeal of SOCE; some men who sought SOCE described feeling distress about not acting more traditionally masculine. In reviewing the SOCE literature, Miville and Ferguson (2004) proposed that White, conservatively religious men might not feel adept at managing a minority status and thus seek out SOCE as a resolution.

Licensed mental health providers' views about SOCE and homosexuality appear to influence clients' decision making in choosing SOCE; some clients reported being urged by their provider to participate in SOCE (M. King et al. 2004; Schroeder & Shidlo, 2001; Smith et al., 2004). For example, Smith et al. (2004) found that some who had received SOCE had not requested it. These individuals stated they had presented with confusion and distress about their orientation due to cultural and relational conflicts and were offered SOCE as the solution.

Specific Concerns of Religious Individuals

In general, the participants in research on SOCE have come from faiths that believe heterosexuality and other-sex relationships are part of the natural order and are morally superior to homosexuality (Beckstead & Morrow, 2004; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001, 2006). The literature on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid (Beckstead & Morrow, 2004; Erzen, 2006; Glassgold, 2008; Mark, 2008; Nicolosi et al., 2000; Ponticelli, 1999; Wolkomir, 2001, 2006).

The experiences of some conservative religious individuals with same-sex sexual attractions who undergo SOCE appear to involve significant stress due to the struggle to live life congruently with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse & Tan, 2004). These individuals perceive homosexuality to be irreconcilable with their faith and do not wish to surrender or change their faith (Wolkomir, 2006). Some report fearing considerable shifts or losses in their core identity, role, purpose, and sense of order if they were to pursue an outward LGB identity (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Wolkomir, 2006). Some report difficulty coping with intense guilt over the failure to live a virtuous life and inability to stop committing unforgivable sins, as defined by their religion (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008). Some struggled with the belief in their Higher Power, with the perception that this Power was punishing or abandoning them—or would if they acted

on their attractions; some expressed feelings of anger at the situation in which their Power had placed them (Beckstead & Morrow, 2004; Glassgold, 2008; cf. Exline, 2002; Pargament, Smith, Koenig, & Perez, 1998, 2005).

Some individuals' distress took the form of a crisis of faith in which their religious beliefs that a same-sex sexual orientation and religious goodness are diametrically opposed led them to question their faith and themselves (Glassgold, 2008; Moran, 2007; Tozer & Hayes, 2004). Spiritual struggles also occurred for religious sexual minorities due to struggling with conservatively religious family, friends, and communities who thought differently than they did. The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation (Beckstead & Morrow, 2004).

The distress experienced by religious individuals appeared intense, for not only did they face sexual stigma from society at large but also messages from their faith that they were deficient, sinful, deviant, and possibly unworthy of salvation unless they changed sexual orientation.

These spiritual struggles had mental health consequences. Clinical publications and studies of religious clients (both male and female) (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004; Mark, 2008) have described individuals who felt culpable, unacceptable, unforgiven, disillusioned, and distressed due to the conflict between their same-sex sexual attractions and religion. The inability to integrate religion and sexual orientation into a religiously sanctioned life (i.e., one that provides an option for positive self-esteem and religiously sanctioned sexuality and family life) has been described as causing great emotional distress (Beckstead & Morrow, 2004; Glassgold, 2008; Mark, 2008; D. F. Morrow, 2003). These spiritual struggles were sometimes associated with anxiety, panic disorders, depression, and suicidality, regardless of the level of religiosity or the perception of religion as a source of comfort and coping (Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004). The emotional reactions reported in the literature on SOCE among religious individuals are consistent with the literature in the psychology of religion that describes both the impact of an inability to live up to religious motivations and the effects of religion and positive and negative religious coping (Ano & Vasconcelles, 2005; Exline, 2002; Pargament & Mahoney, 2002; Pargament et al., 2005; Trenholm, Trent, & Compton, 1998).

Some individuals coped by trying to compartmentalize their sexual orientation and religious identities and behaviors or to suppress one identity in favor of another (Beckstead & Morrow, 2004; Haldeman, 2004; Glassgold, 2008; Mark, 2008). Relief came as some sought repentance from their "sins," but others continued to feel isolated and unacceptable in both religious and sexual minority communities (Shidlo & Schroeder, 2002; Yarhouse & Beckstead, 2007). As an alternative, some with strong religious motivations and purpose were willing to make sexual abstinence a goal and to limit sexual and romantic needs in order to achieve congruence with their religious beliefs (S. L. Jones & Yarhouse, 2007; Yarhouse et al., 2005; Yarhouse, 2008). These choices are consistent with the psychology of religion that emphasizes religious motivations and purpose (cf. Emmons, 1999; Emmons & Paloutzian, 2003; Hayduk, Stratkotter, & Rovers, 1997; Roccas, 2005). Success with this choice varied greatly and appeared successful in a minority of participants of studies, although not always in the long term, and both positive and negative mental heath effects have been reported (Beckstead & Morrow, 2004; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Shidlo & Schroeder, 2002).

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

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

[39] Among Jewish traditions, Orthodox Judaism is the most conservative and does not have a role for same-sex relationships or sexual orientation identities within its faith (Mark, 2008). Individuals

2008; Glassgold, 2008; Mark, 2008; Wolowelsky & Weinstein, 1995). This work stresses the conflicts that emerge within a communal and insular culture that values obedience to religious law and separates itself from mainstream society and other faiths, including mainstream LGB communities, thus isolating those in conflict and distress (Glassgold, 2008; Mark, 2008). As marriage, family, and community are the central units of life within such a religious context, LGB individuals do not have a place in Orthodox Judaism and traditional Jewish society and may fear losing contact with family and society or bringing shame and negative consequences to their family if their sexual orientation is disclosed.[40] Many of the responses and concerns of the conservative Christian population appear relevant to those who are Orthodox Jews, especially those that arise from the conflicts of faith and sexual orientation, such as feelings of guilt, doubt, crisis of faith, unworthiness, and despair (Glassgold, 2008; Mark, 2008).

We found no scholarly psychological literature on sexual minority Muslims who seek out SOCE. There is some literature on debates about homosexuality within Islam and cultural conflicts for those Muslims who live in Western societies with more progressive attitudes toward homosexuality (Halstead & Lewicka, 1998; Hekma, 2002; de Jong & Jivraj, 2002; Massad, 2002; Nahas, 2004). Additionally, there is some literature on ways in which individuals integrate LGBT identities with their Muslim faith (Minwalla, Rosser, Feldman, & Varga, 2005; Yip, 2005). We did not find scholarly articles about individuals from other faiths who sought SOCE, except for one article (Nicolosi et al., 2000) that that did not report any separate results for individuals from non-Christian faiths.

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It is important to note that not all sexual minorities with strong religious beliefs experience sexual orientation distress, and some resolve such distress in other ways than SOCE (Coyle & Rafalin, 2000; Mahaffy, 1996; O'Neill & Ritter, 1992; Ritter & O'Neill, 1989, 1995; Rodriguez & Ouellette, 2000; Rodriguez, 2006; Yip, 2000, 2002, 2003, 2005). For instance, some individuals are adherents of more accepting faiths and thus experience less distress. Some end their relationship with all religious institutions, although they may retain the religious and spiritual aspects of their original faiths that are essential to them. Others choose another form of religion or spirituality that is affirming of sexual minorities (Lease, Horne, & Noffsinger-Frazier, 2005; Ritter & O'Neill, 1989, 1995; Ritter & Terndrup, 2002; Rodriguez & Ouellette, 2000; Yip, 2000, 2002, 2003, 2004).

Conflicts of Individuals in Other-Sex Marriages or Relationships

There is some indication that some individuals with same-sex sexual attractions in other-sex marriages or relationships may request SOCE. Many subjects in the early studies were married (H. E. Adams & Sturgis, 1977). In the more recent research, some individuals were married (e.g., Horlacher, 2006; Spitzer, 2003), and there are clinical reports of experiences of SOCE among other-sex married people (e.g., Glassgold, 2008; Isay, 1998). For some, the marriage to another-sex person was described as based on socialization, religious views that deny same-sex sexual attractions, lack of awareness of alternatives, and hopes that marriage would change them (Gramick, 1984; Higgins, 2006; Isay, 1998; Malcolm, 2000; Ortiz & Scott, 1994; M. W. Ross, 1989). Others did not recognize or become aware of their sexuality, including same-sex sexual attractions, until after marriage, when they became sexually active (Bozett, 1982; Carlsson, 2007; Schneider et al. 2002). Others had attractions to both men and women (Brownfain, 1985; Coleman, 1989; Wyers, 1987).

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

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

[40] These conflicts may also be relevant to those whose religion and community are similarly intertwined and separate from larger society; see Cates (2007), for instance, regarding an individual from an Old Amish community.

& Tan, 2003; Yarhouse & Seymore, 2006). Thus, the sexual minority individual sometimes felt frustrated and hopeless in facing feelings of loss and guilt that result from trying to decide whether to separate from or remain in the marriage as they balanced hopes and ambiguities (e.g., the chances of finding a same-sex romantic or sexual partner or the possibilities of experiencing further intimacy with one's heterosexual spouse) (Hernandez & Wilson, 2007).

Reported Impacts of SOCE

Perceived Positives of SOCE

In this section we review the perceptions of individuals who underwent SOCE in order to examine what may be perceived as being helpful or detrimental by such individuals, distinct from a scientific evaluation of the efficacy or harm associated with sexual orientation change efforts, as reported in Chapter 4.

Individuals have reported that SOCE provided several benefits: (a) a place to discuss their conflicts (Beckstead & Morrow, 2004; Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001); (b) cognitive frameworks that permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem (Erzen, 2006; Karten, 2006; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton, 2002); (c) social support and role models (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006); and (d) strategies for living consistently with their religious faith and community (Beckstead & Morrow, 2004; Erzen, 2006; Horlacher, 2006; S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Robinson, 1998; Wolkomir, 2001, 2006; Throckmorton & Welton, 2005).

For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, sexual orientation identity (Beckstead, 2001; Nicolosi et al., 2000; Schaeffer et al., 2000; Spitzer, 2003; Throckmorton & Welton, 2005), or improving nonsexual relationships with men (Karten, 2006). These changes in sexual self-views were described in a variety of ways (e.g., ex-gay, heterosexual, heterosexual with same-sex sexual attractions, heterosexual with a homosexual past) and with varied and unpredictable outcomes, some of which were temporary (Beckstead, 2003; Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). McConaghy (1999) reported that some men felt they had more control in their sexual behavior and struggled less with their attractions after interventions, although same-sex sexual attractions still existed (cf. Beckstead & Morrow, 2004). Additionally, some SOCE consumers describe that trying and failing to change their same-sex sexual orientation actually allowed them to accept their same-sex attractions (Beckstead & Morrow, 2004; Smith et al., 2004).

Participants described the social support aspects of SOCE positively. Individuals reported as positive that their LMHP accepted their goals and objections and had similar values (i.e., believing that a gay or lesbian identity is bad, sick, or inferior and not supporting same-sex relationships) (Nicolosi et al., 2000; Throckmorton & Welton, 2005). Erzen (2006), Ponticelli (1999), and Wolkomir (2001) described these religiously-oriented ex-gay groups as a refuge for those who were excluded both from conservative churches and from their families, because of their same-sex sexual attractions, and from gay organizations and social networks, because of their conservative religious beliefs. In Erzen's experiences with these men, these organizations seemed to provide options for individuals to remain connected to others who shared their religious beliefs, despite ongoing same-sex sexual feelings and behaviors. Wolkomir (2006) found that ex-gay groups recast homosexuality as an ordinary sin, and thus salvation was still achievable. Erzen observed that such groups built hope, recovery, and relapse into an ex-gay identity, thus expecting same-sex sexual behaviors and conceiving them as opportunities for repentance and forgiveness.

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

described that ex-gay support groups provide alternate ways of viewing same-sex attractions that permit individuals to see themselves as heterosexual, which provided individuals a sense of possibility.

Participants' interpretations of their SOCE experiences and the outcomes of their experiences appeared to be shaped by their religious beliefs and by their motivations to be heterosexual. In Schaeffer et al. (2000), people whose motivation to change was strongly influenced by their Christian beliefs and convictions were more likely to perceive themselves as having a heterosexual sexual orientation after their efforts. Schaeffer et al. also found that those who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. Some of the respondents in Spitzer's (2003) study concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions. These findings underscore the importance of the nature and strength of participants' motivations, as well as the importance of religious identity in shaping self-reports of perceived sexual orientation change.

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A number of authors (Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001; Yarhouse et al., 2005; Yarhouse & Tan, 2004) have found that identity exploration and reinterpretation were important parts of SOCE. Beckstead and Morrow (2004) described the identity development of their research participants who were or had been members of the Church of Jesus Christ of Latter-Day Saints and had undergone therapy to change their sexual orientation to heterosexual. In this research, those who experienced the most satisfaction with their lives seemed to undergo a developmental process that included the following aspects: (a) becoming disillusioned, questioning authorities, and reevaluating outside norms; (b) wavering between ex-gay, "out" gay, heterosexual, or celibate identities that depended on cultural norms and fears rather than on internally self-informed choices; and (c) resolving their conflicts through developing self-acceptance, creating a positive self-concept, and making decisions about their relationships, religion, and community affiliations based on expanded information, self-evaluations, and priorities. The participants had multiple endpoints, including LGB identity, "ex-gay" identity, no sexual orientation identity, and a unique self-identity. Some individuals chose actively to *disidentify* with a sexual minority identity so the individual's sexual orientation identity and sexual orientation may be incongruent (Wolkomir, 2001, 2006; Yarhouse, 2001; Yarhouse & Tan, 2004; Yarhouse et al., 2005).

Further, the findings suggest that some participants may have reconceptualized their *sexual orientation identity* as heterosexual but *not* achieved sexual orientation change, as they still experienced same-sex sexual attractions and desires (for a discussion of the distinction between sexual orientation and sexual orientation identity, see Chapter 3; see also R. L. Worthington, 2003; R. L. Worthington et al., 2002). For these individuals, sexual orientation identity may not reflect underlying attractions and desires (Beckstead, 2003; Beckstead & Morrow, 2004; McConaghy, 1999; Shidlo & Schroeder, 2002).

Perceived Negatives of SOCE

Participants in the studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) described the harm they experienced as (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. Interpreting SOCE failures as individual failures was also reported in this research, in that individuals blamed themselves for the failure (i.e., weakness, and lack of effort, commitment, faith, or worthiness in God's eyes). Intrusive images and sexual dysfunction were also reported, particularly among those who had experienced aversion techniques.

Participants in these studies related that their relationships with others were also harmed in the following ways: (a) hostility and blame toward parents due to believing they "caused" their homosexuality; (b) anger at and a sense of betrayal by SOCE providers; (c) loss of LGB friends and potential romantic partners due to beliefs they should avoid sexual minority people; (d) problems in sexual and emotional intimacy with other-sex partners, (e) stress due to the negative emotions of spouses and family members because of expectations that SOCE would work (e.g., disappointment, self-blame for failure of change,

perception of betrayal by partner) (see also J. G. Ford, 2001); (f) guilt and confusion when they were sexually intimate with other same-sex members of the ex-gay groups to which they had turned for help in avoiding their attractions.

Licensed mental health providers working with former participants in SOCE noted that when clients who formerly engaged in SOCE consider adopting an LGB identity or experience same-sex romantic and sexual relationships later in life, they have more difficulty with identity development due to delayed developmental tasks and dealing with any harm associated with SOCE (Haldeman, 2001; Isay, 2001). Such treatments can harm some men's understanding of their masculine identity (Haldeman, 2001; Schwartzberg & Rosenberg, 1998) and obscure other psychological issues that contribute to distress (Drescher, 1998a).

These individuals identified aspects of SOCE that they perceived as negative, which included (a) receiving pejorative or false information regarding sexual orientation and the lives of LGB individuals; (b) encountering overly directive treatment (told not to be LGB) or to repress sexuality; (c) encountering treatments based on unsubstantiated theories or methods; (d) being misinformed about the likelihood of treatment outcomes (i.e. sexual orientation change); (e) receiving inadequate information about alternative options; and (f) being blamed for lack of progress of therapy. Some participants in Schroeder and Shidlo's (2001) study reported feeling coerced by their psychotherapist or religious institution to remain in treatment and pressured to represent to others that they had achieved a "successful reorientation" to heterosexuality.

Religiously Oriented Mutual Support Groups

Much of the literature discusses the specific dynamics and processes of religiously oriented mutual self-help groups. A reduction of distress through sexual orientation identity reconstruction or development is described in the literature of self-help or religious groups, both for individuals who reject (Erzen, 2006; Ponticelli, 1999; Wolkomir, 2001, 2006) and for individuals who accept a minority sexual orientation identity (Kerr, 1997; Rodriguez, 2006; Rodriguez & Ouellette, 2000; Thumma, 1991; Wolkomir, 2006).

Ponticelli (1999) and Wolkomir (2001, 2006) found several emotional and cognitive processes that seemed central to the sexual orientation "identity reconstruction" (i.e., recasting oneself as ex-gay, heterosexual, disidentifying as LGB) (Ponticelli, 1999, p. 157) that appeared to relieve the distress caused by conflicts between religious values and sexual orientation (Ponticelli, 1999). Ponticelli identified certain conditions necessary for resolving identity conflicts, including (a) adopting a new discourse or worldview, (b) engaging in a biographical reconstruction, (c) embracing a new explanatory model, and (d) forming strong interpersonal ties. For those rejecting a sexual minority identity, these changes occurred by participants taking on "ex-gay" cultural norms and language and finding a community that enabled and reinforced their primary religious beliefs, values, and concerns. For instance, participants were encouraged to rely on literal interpretations of the Bible, Christian psychoanalytic theories about the causes of homosexuality, and "ex-gay" social relationships to guide and redefine their lives.

Interesting counterpoints to the SOCE support groups are LGB-affirming religious support groups. These groups employ similar emotional and cognitive strategies to provide emotional support, affirming ideologies, and identity reconstruction. Further, they appear to facilitate integration of same-sex sexual attractions and religious identities into LGB-affirming identities (Kerr, 1997; Thumma, 1991; Wolkomir, 2001, 2006).

Both sexual-minority-affirming and ex-gay mutual help groups potentially appear to offer benefits to their participants that are similar to those claimed for self-help groups, such as social support, fellowship, role models, and new ways to view a problem through unique philosophies or ideologies (Levine, Perkins, & Perkins, 2004).

Mutual help groups' philosophy often gives a normalizing meaning to the individual's situation and may act as an "antidote" to a sense of deficiency (Antze, 1976). New scripts can shape how a member views and shares her or his life story by replacing existing personal or cultural scripts with the group ideology (Humphreys, 2004; Mankowski, 1997, 2000; Maton, 2000). For instance, individuals who are involved in SOCE or LGB-affirming groups may adopt a new explanation for their homosexuality that permits reconceptualizing themselves as heterosexual or acceptable as LGB people (Ponticelli, 1999; Wolkomir, 2001, 2006).

Remaining Issues

Ponticelli (1999) ended her article with the following questions: "What leads a person to choose Exodus and a frame that defined them as sinful and in need of change?" (p. 170). Why do some individuals choose SOCE over sexual-minority-affirming groups, and why are some individuals attracted to and able to find relief in a particular ideology or group over other alternatives?

There are some indications that the nature and type of religious motivation and faith play a role. In comparing individuals with intrinsic[41] and quest religious motivations, Tozer and Hayes (2004) proposed that those with a greater intrinsic religiosity may be motivated to seek out SOCE more than those with the quest motivation. However, within both groups (intrinsic and quest motivation), internalized stigma influenced who sought SOCE; those who sought SOCE had higher levels of internalized stigma. Tozer and Hayes (2004) and Mahaffy (1996) found that individuals in earlier stages of sexual minority identity development (see, e.g., Cass, 1979; Troiden, 1993) were more likely to pursue SOCE.

Wolkomir (2001, 2006) found some evidence that biographical factors may be central to these choices. Wolkomir (2006) found that motivations for participation in faith distinguished individuals who joined ex-gay groups from sexual-minority-affirming groups. For instance, men who joined conservative Christian communities as a solution to lives that had been lonely and disconnected and those who turned to faith when they felt overwhelmed by circumstance were more likely to join ex-gay groups. Wolkomir hypothesized that these men perceived homosexuality as a threat to the refuge that conservative faith provided (cf. Glassgold, 2008).

The other common path to an ex-gay (as well as, to some degree, to a sexual-minority-affirming) group was remaining in the community of faith in which one was raised and meeting the expectations of that faith, such as heterosexuality. The loss of a personal relationship or a betrayal by a loved one might influence an individual's choice of a group, and the stress of loss and the self-blame that accompany such a loss may constitute factors that lead someone to seek SOCE (Wolkomir, 2001, 2006).

Additionally, Wolkomir found that a sense of gender inadequacy (see also "gender role strain"; Levant, 1992; Pleck, 1995) made groups that embraced traditional gender roles and gender-based models of homosexuality appealing to some men. Gender-based internalized stigma and self-stigma increased distress in these men.

Finally, "contractual promises" to God (Wolkomir, 2001, p. 332) regarding other concerns (e.g., drug/alcohol abuse) increased the likelihood that men would choose ex-gay groups. However, these issues are as yet underresearched and remain unresolved.

Very little is known about the concerns of other religious faiths and diverse ethnicities and cultures (Harper et al., 2004; Miville & Ferguson, 2004). There are some studies in the empirical and theoretical literature, clinical cases, and material from other fields (e.g., anthropology, sociology) on sexual orientation among ethnic minorities and in different cultures and countries. Sexual orientation identity may be constructed differently in ethnic minority communities and internationally (Carillo, 2002; Boykin, 1996; Crawford et al., 2002; Harper et al., 2004; Mays, Cochran, & Zamudio, 2004; Miville & Ferguson, 2004; Walters, Evans-Campbell, Simoni, Ronquillo, & Bhuyan, 2006; Wilson & Miller, 2002; Zea, Diaz, & Reisen, 2003). There is some information that such populations experience distress or conflicts due to legal discrimination, cultural stigma, and other factors (McCormick, 2006), and in some other countries, homosexuality is still seen as a mental disorder or is illegal (Forstein, 2001; International Gay & Lesbian Human Rights Commission, n.d.). We did not identify empirical research on members of these populations who had sought or participated in SOCE other than as part of the research already cited.

Summary and Conclusion

The recent literature identifies a population of predominantly White men who are strongly religious and participate in conservative faiths. This contrasts with the early research that included nonreligious individuals who chose SOCE due to the prejudice and discrimination caused by sexual stigma. Additionally, there is a lack of research on non-Christian individuals and limited information on ethnic minority populations, women, and nonreligious populations.

The religious individuals in the recent literature report experiencing serious distress, including depression, identity, confusion, and fear due to the strong prohibitions of their faith regarding same-sex sexual orientation, behaviors, and relationships.

[41] Internal motivation refers to a motivation that focuses on belief and values as ends in themselves, and quest sees religion as a process of exploration.

These individuals struggle to combine their faiths and their sexualities in meaningful personal and social identities. These struggles cause them significant distress, including frequent feelings of isolation from both religious organizations and sexual minority communities. The ensuing struggles with faith, sexuality and identity lead many individuals to attempt sexual orientation change through professional interventions and faith-based efforts.

These individuals report a range of effects from their efforts to change their sexual orientation, including both benefits and harm. The benefits include social and spiritual support, a lessening of isolation, an understanding of values and faith and sexual orientation identity reconstruction. The perceived harms include negative mental health effects (depression and suicidality), decreased self-esteem and authenticity to others, increased self-hatred and negative perceptions of homosexuality; a loss of faith, and a sense of having wasted time and resources.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means to resolve the distress caused by conflicts between religious values and sexual orientation.

Mutual self-help groups (whether affirming or rejecting of sexual minorities) may provide a means to resolve the distress caused by conflicts between religious values and sexual orientation (Erzen, 2006; Kerr, 1997; Ponticelli, 1999; Thumma, 1991; Wolkomir, 2001, 2006). Sexual orientation identity reconstruction found in such groups (Ponticelli, 1999; Thumma, 1991) and identity work in general may provide reduction in individual distress (Beckstead & Morrow, 2004). Individuals may seek out sexual-minority-affirming religious groups or SOCE in the form of ex-gay religious support groups due to (a) a lack of other sources of social support; (b) a desire for active coping, including both cognitive and emotional coping (Folkman & Lazarus, 1980); and (c) access to methods of sexual orientation identity exploration and reconstruction (Ponticelli, 1999; Wolkomir, 2001).

The limited information provided by the literature on individuals who experience distress with their sexual attractions and seek SOCE provides some direction to LMHP in formulating affirmative interventions for this population. The following appear to be helpful to clients:

- Finding social support and interacting with others in similar circumstances
- Experiencing understanding and recognition of the importance of religious beliefs and concerns
- Receiving empathy for their very difficult dilemmas and conflicts
- Being provided with affective and cognitive tools for identity exploration and development

Reports of clients' perceptions of harm also provide information about aspects of interventions to avoid:

- Overly directive treatment that insists on a particular outcome
- Inaccurate, stereotypic, or unscientific information or lack of positive information about sexual minorities and sexual orientation
- The use of unsound or unproven interventions
- Misinformation on treatment outcomes

It is important to note that the factors that are identified as benefits are not unique to SOCE and can be provided within an affirmative and multiculturally competent framework that can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs. An approach that integrates the information identified in this chapter as helpful is described in an affirmative model of psychotherapy in Chapter 6.

Attachment 5

NJ judge finds gay conversion therapy claims amount to consumer fraud

Judge compares conversion claims to flat-earth theory

02/17/2015 | ConsumerAffairs | Deceptive Advertising (http://www.consumeraffairs.com/false-and-deceptive-advertising)

By James R. Hood

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A New Jersey judge has ruled that "conversion therapy" services that claim they can "cure" homosexuals are violating the state's Consumer Fraud Act by depicting homosexuality as abnormal or a mental illness.

Hudson County Judge Peter Bariso Jr. likened the theory that homosexuality can be cured to the notion that the earth is flat, saying that both have been disproven by scientific evidence.

Bariso also held that advertising the conversion services without compelling scientific evidence to support their claims also amounted to consumer fraud.

The decision makes "all the sense in the world," said Hayley Gorenberg, of Lambda Legal in New York. Marlton, N.J., attorney Joseph Osefchen said conversion therapy advertisements are a "class action waiting to happen," the New Jersey Law Journal (http://www.njlawjournal.com/id=1202717571907/Gay-Conversion-Therapy-Consumer-Fraud-Ruling-First-in-US?slreturn=20150117110126) reported.

The case was brought by the Southern Poverty Law Center (SPLC) on behalf of four young men who had obtained conversion therapy through Jews Offering New Alternatives for Healing (JONAH).

JONAH lead counsel Charles LiMandri said his clients were “devout Jewish people” who did not say homosexuality is a mental illness but will say that “in the context of the Torah, that it is not part of God’s plan.”

He added that “people may disagree, they may even be very offended, but it’s a traditional Judeo-Christian belief.”

According to the SPLC, the ruling marks the first time a U.S. court has found that homosexuality is not a mental disease.

"This ruling makes clear that when conversion therapists lie about the nature of homosexuality in order to lure these vulnerable clients into their services and their programs, they're committing fraud," said David Dinielli, deputy legal director of the Southern Poverty Law Centre (http://www.splcenter.org/) which filed the lawsuit for the plaintiffs.

Browsing Topic: **Deceptive Advertising (http://www.consumeraffairs.com/false-and-deceptive-advertising)**

Attachment 6

Medical Professionals Address Conversion Therapy

Because of the aggressive promotion of efforts to change sexual orientation through therapy, a number of medical, health and mental health professional organizations have issued public statements about the dangers of this approach. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the American School Counselor Association, the National Association of School Psychologists and the National Association of Social Workers together, representing more than 480,000 mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus is not something that needs to or can be "cured."

The **American Academy of Pediatrics** advises youth that *counseling may be helpful for you if you feel confused about your sexual identity. Avoid any treatments that claim to be able to change a person's sexual orientation, or treatment ideas that see homosexuality as a sickness.*[8]

The **American Counseling Association** adopted a resolution in 1998 stating that it *opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation; and supports the dissemination of accurate information about sexual orientation, mental health, and appropriate interventions in order to counteract bias that is based on ignorance or unfounded beliefs about same-gender sexual orientation.9 Further, in April 1999, the ACA Governing Council adopted a position opposing the promotion of "reparative therapy" as a "cure" for individuals who are homosexual.*[10]
In addition, ACA's Code of Ethics states:
Counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. Counselors who do not must define the techniques/procedures as "unproven" or "developing" and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm.[11]

The **American Psychological Association,** in its 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation, which is also endorsed by the National Association of School Psychologists, states:
That the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation and mental health and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation.[12]

The **American Psychiatric Association,** in its 2000 position statement on "reparative" therapy, states:
Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.
The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior…

Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation.[13]

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The **American School Counselor Association,** in its position statement on professional school counselors and lesbian, gay, bisexual, transgendered and questioning youth, states: *Lesbian, gay, bisexual, transgendered and questioning (LGBTQ) youth often begin to experience self-identification during their pre-adolescent or adolescent years, as do heterosexual youth. These developmental processes are essential cognitive, emotional and social activities, and although they may have an impact on student development and achievement, they are not a sign of illness, mental disorder or emotional problems nor do they necessarily signify sexual activity. . . .*
It is not the role of the professional school counselor to attempt to change a student's sexual orientation/gender identity but instead to provide support to LGBTQ students to promote student achievement and personal well-being. . . .
Recognizing that sexual orientation is not an illness and does not require treatment, professional school counselors may provide individual student planning or responsive services to LGBTQ students to promote self-acceptance, deal with social acceptance, understand issues related to "coming out," including issues that families may face when a student goes through this process, and identify appropriate community resources.[14]

The **National Association of Social Workers,** in its policy statement on lesbian, gay and bisexual issues, states that it *endorses policies in both the public and private sectors that ensure nondiscrimination; that are sensitive to the health and mental health needs of lesbian, gay and bisexual people; and that promote an understanding of lesbian, gay and bisexual cultures. Social stigmatization of lesbian, gay, and bisexual people is widespread and is a primary motivating factor in leading some people to seek sexual orientation changes.*[17] *Sexual orientation conversion therapies assume that homosexual orientation is both pathological and freely chosen. No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful.*[18] *NASW believes social workers have the responsibility to clients to explain the prevailing knowledge concerning sexual orientation and the lack of data reporting positive outcomes with reparative therapy. NASW discourages social workers from providing treatments designed to change sexual orientation or from referring practitioners or programs that claim to do so.*[17] *NASW reaffirms its stance against reparative therapies and treatments designed to change sexual orientation or to refer practitioners or programs that claim to do so.*[18]

As these statements make clear, the nation's leading professional medical, health and mental health organizations do not support efforts to change young people's sexual orientation through therapy and have raised serious concerns about the potential harm from such efforts.

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[8] American Academy of Pediatrics. (2001). Gay, lesbian and bisexual teens: Facts for teens and their parents [Pamphlet]. Elk Grove, IL: Author.

[9] Resolution adopted by American Counseling Association Governing Council, March 1998.

[10] Action by American Counseling Association Governing Council, April 1999.

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