

NARTH COMMITTEE RESPONSE TO APA REPORT
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Response to the APA report “Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation.”

N.E.Whitehead, Ph.D.

Summary:

This paper asserts that the APA’s labeling of homosexuality as “normal” is a value judgment which, contrary to the task force’s assertion, does not come from science. It further asserts that the extreme health risks homosexual males take is *ipso facto* a treatable mental illness. It also argues that the failure of the task force to understand the intellectual history of what causes homosexuality, means its criticisms of sociological surveys supportive of traditional therapies are misconceived. The genesis of homosexuality is so individualistic that sociological surveys often fail to capture the individualistic threads, and individual case studies should have been emphasised. The alternative gay-affirmative therapies advocated by the committee are relatively untried and demand an even higher standard of proof than that demanded for the traditional therapies.

“Normal” is a value word not a scientific word

In this paper those therapists who offer the possibility of change to homosexual people are called “traditional therapists”, because as mentioned (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009) this therapy has a history covering much of last century.

There are many of us out here, who believe several of the basic positions of the APA on homosexuality are scientific nonsense and have believed this for 30 years and more (specifically the alleged normality of the condition and the alleged lack of accompanying pathology). Some of this occurs again in the report..

The most basic bit of philosophical nonsense in the report is that it is a scientific fact that homosexuality is normal. Use of this principle is advocated by the task force as a means of educating people that it is ethically OK to be homosexual. It is a very clear ethical value judgment. As a practicing scientist I say that this statement of normality is either completely vacuous or elevates science into a religion, both of which are deplorable..

If the statement that homosexuality is normal means that homosexuality is widespread, occurs in society, and this is established as a scientific fact, we agree the surveys show it is widespread. But to tack the value-word “normal” onto it is elementary nonsense. Anyone in introductory philosophy classes learns that it is a logical fallacy to say that because something IS, that it is right or wrong. (The task force cannot mean this

otherwise it must say that therapies which attempt to treat homosexuality are also normal and right by virtue of their existence)

Science can only be made to say that some things are right or wrong or “normal” if it has become the slave of religious or philosophical ideology. Value statements about homosexuality do not come from science but politics. Saying the concept of ethical normality comes from science is attaching a false authority to their statement.

Mental illness

The APA well knows that very many still hotly contest their view that homosexuality *per se* has no intrinsic element of mental illness associated with it. The view of traditional therapists can be summed up thus:

At the most extreme a large fraction of homosexual men prefer death to adopting safer sex.

Although not an explicit DSM standard this is obviously a mental illness. Any responsible therapist, if asked, would treat such a condition.

The authors of the report list reasons for seeking therapy, and fear of health consequences is not listed - or is perhaps very minor. Assuming this is true, it is remarkable, and further evidence of cognitive disturbance.

(This applies to extreme promiscuity in the heterosexual sphere as well, but in the West the risk of death from heterosexual hypersexuality is so low that it is rarely mentally aberrant in that sense.)

Presenting to the public the idea that there is no mental illness associated with homosexuality is highly misleading.

Standards of proof

Therapists have been offering therapies to help homosexuals for many decades. However the task force now demands a standard of proof of effectiveness which appears impossibly high and is not required of other therapies. A good name for this might be “victimization”. The “success rates” of various therapies for addiction are similar to those for homosexual-related therapy – but addiction therapies (for example) are never attacked on the grounds that they have not been subjected to the impossibly rigorous tests proposed for traditional therapy for homosexuals. The only rigorous survey would be a longitudinal comparison of “treatment” and “no treatment”. But presenting clients usually have co-morbid problems particularly suicidality, mood disorders and substance abuse so “no treatment” is not an ethical option. This means a rigorous test is impossible. The Task Force’s insistence on such high standards of proof for traditional homosexual

therapies is so highly selective it can only be political, and is hence very reprehensible in an organization trying to give an impression of being wholly science-based.

Would the committee recommend that therapy for alcoholism be not attempted because it will probably not work? Statistically the truth is that in most cases it doesn't. The ethical position must surely be that anything that may work should be tried, though with appropriate safeguards.

Along with this an alternative gay-affirmative therapy is advocated. Given the Task Force's stated position, the same research standards must be applied to testing whether affirmative therapy works. In fact higher standards must be demanded because it is largely untried compared with the wealth of experience gained over many decades for the traditional therapies. Some common sense is needed. Traditional therapies which advocate at least same-sex sexual abstinence, must save many lives, even if no good survey has been done to support that. An alternative therapy which allows or encourages expression of an intense sexuality which often causes premature death through misadventure must meet extremely high standards of proof to be declared safe. Probably such experimental treatment is currently unethical.

Spontaneous change in attraction

A basic point of contention is whether attractions change. The literature shows that same-sex attraction is much more basic and less socially constructed than modern gay identity. The question is: can/do attractions change? The authors did not adequately review the significant literature which mentions how surveys show spontaneous change in attractions takes place. This has been well known since the time of Kinsey who reported many such cases of change to greater or lesser degrees. This has been followed by many such reports. Approximately 3% of the heterosexual population once believed they were homosexual or bisexual because of the appropriate attractions. Significant change in attraction takes place in both directions on the heterosexual-bisexual-homosexual continuum (Kinnish, Strassberg, & Turner, 2005). This is not adequately described as merely "fluidity". If spontaneous change takes place, surely therapeutically assisted change has an even better chance?

Misinterpreted research, ignorance of intellectual history

The report contains a complete misinterpretation of the intellectual history of research into homosexuality. Following a common and completely mistaken thread they assert that the work of Bell, et al. (Bell, Weinberg, & Hammersmith, 1981) and their successors showed that no family factor has any effect on the genesis of homosexuality. This is quite wrong, as discussed in the successful replication of their work by Van Wyk and Geist (Van Wyk & Geist, 1984). The paths to adult homosexuality Bell et al. found, accounted for 30% of the variance, which is a good and significant result by the standards of sociological surveys. This *unequivocally* means that social factors *as a whole* are significant. (But other factors are also involved, since less than half the variance is accounted for). However Bell et al also found that any *individual* path or sequence

although statistically significant had a very small effect size (in today's terminology). No individual path is the dominant one as amply confirmed by much other research. Nor will exposure of individuals to any known factor cause more than a very small proportion to become homosexual. This shows clearly that there are a large number of individualistic reactions and social-factor paths to the end point of adult homosexuality. It means that because many social factors are involved that therapy has a chance of promoting change. It also means that sociological surveys of homosexuality have a strong chance of not capturing truth for individuals, e.g. significant change.

The problem here is a confusion between a sociological viewpoint and a clinical one. (Whitehead, 1996) Sociological surveys give the grand mean for a group of people but must ignore individual particularities. Sociologists have a bad tendency to make incorrect claims about individuals based on sociological surveys which hide individual differences. Conversely a clinician may gain great insights about individuals from in depth interviews. However clinicians have a bad tendency to make incorrect claims about the general population based on their limited sample.

Subsequent intellectual history not mentioned by the task force supports the above interpretation. The consistent outcome of extensive twin studies, (Hershberger, 1997), (Bailey, Dunne, & Martin, 2000), (Kendler, Thornton, Gilman, & Kessler, 2000; Bearman & Bruckner, 2002), (Santtila et al., 2008), (Langstrom, Rahman, Carlstrom, & Lichtenstein, 2008) is that there is a combined dominant cause of homosexuality but it is the class of individual non-shared experience, or more probably different reactions to the same experiences, exemplified by the fact that if one identical twin has same sex-attraction the co-twin overwhelmingly does not. No shared factor, social or genetic is predominant.

Since the science establishes that there is a primacy of the *individual* experience, criticisms of the methodological weaknesses of surveys are a pointless counsel of perfection. Therapies, and individual experiences are so varied that it is most impressive there is any coherence at all in the overall picture captured by surveys. These changes are more striking when they are in the form of individual stories, and it is those which are most important.

Because in any therapy (sexual or not) some do not change, some change a little and some change a lot, testing whether change is real or possible (the point at issue here) should not use the average of a sociological survey, which will only show a small or even non-significant change on average, but the reality/or otherwise of the greatest change for any individual in the group. This is a illustration of what change is potentially possible. Looking closely at the factors involved, skilled therapists then learn how to improve their therapy.

Client satisfaction is a crucial factor in this. It is a valid therapeutic endpoint. The account by the client is paramount. If the client is satisfied with what he/she sees as change, that is change for them.

It may be of theoretical interest to cross question clients very deeply to see characteristics of the change, but our experience is that the current scepticism which drives this is so intense that it can easily amount to a form of intellectual rape. Well enough should be left alone. We find that the most intense questioning comes from those who have not changed, and project their experience onto the population at large. This is quite invalid of course. One individual who testifies to change that satisfies them, outweighs a thousand who have not changed.

We note that the task force treats the sociological survey as the overwhelmingly important methodology for the present investigation, which given the fact that their organization is psychological and would normally put first emphasis on the clinical story is astounding. The sociological is not their primary expertise, and in this case is greatly misapplied.

Stress from minority status has very little empirical support

The authors mentioned coping style, but did not mention that the work of Sandfort et al. (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009) found that differences in coping style accounted for *all* the variance in mental health in their homosexual subjects leaving no room for minority stress. Nor did the task force mention the literature which failed to find much influence of minority stress when searched for, nor the epidemiological work which found for gay-friendly countries such as the Netherlands (Sandfort, de Graaf, Bijl, & Schnabel, 2001) and New Zealand (Fergusson, Horwood, & Beautrais, 1999) that mental health problem prevalence for gays and lesbians were about the same as in the USA (Herrell et al., 1999). Much subsequent work confirms these studies. Minority stress is an attractive hypothesis much canvassed, but has almost no empirical support. Subsequent research concluded that "the risk attached to minority sexual orientation seems to cut across ethnic/racial backgrounds and international boundaries." (Cochran & Mays, 2008)

The authors might reflect that the existence of the traditional therapies has continued for at least 35 years in various forms in spite of a remarkably hostile climate. Neither therapists nor clients have found these therapies in general so unrewarding that they have abandoned the project. There continue to be clients and therapists. This kind of real-life sociological experiment means that traditional therapy clients and their therapists are about as satisfied as is found in other established therapeutic fields.

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Does the APA Report Apply its Research Methodology Standards Consistently? A Preliminary Examination

Christopher Rosick, Ph.D.

The APA's recent task force report, entitled, "Appropriate Therapeutic Responses to Sexual Orientation," contains a major section dedicated to identifying the methodological problems in the research on sexual orientation change efforts (SOCE). This section is meticulous in its efforts to identify any and all limitations to SOCE research with a clear aim of discrediting this literature. While no body of research is free from limitations, one measure of the degree of objectivity behind critiques of this nature is the extent to which they are uniformly applied to research affirmed by the reviewers.

In the case of the APA's report, I was able to locate two articles cited by the task force that was available in full text in the EBSCO database. Research by McCord, McCord, and Thurber (1962) is cited in support of repudiating theories that sexual orientation is associated with family dynamics, gender identity, and trauma. A more recent study by Kurdek (2004) is reported by the task force in support of the essential similarity between gay, lesbian, and heterosexual couples.

A review of the task force's methodological critique of SOCE identified 16 separate concerns that, in the eyes of the task force, are each significant enough on in themselves to call the SOCE research findings into questions. I have listed these concerns in Table 1. My preliminary methodological examination of these articles suggested that, by the APA task for standards, the McCord et al (1960) research committed 10 of the 16 (63%) problems while 2 (13%) additional problems could not be evaluated. The Kurdek research fared slightly better, with only 8 (50%) methodological problems identifiable and another 3 (19%) either not applicable or not able to be evaluated. I will review some of the problems in these studies below, and the reader should keep in mind that these studies were cited uncritically in the task force report.

McCord et al study. The McCord et al (1962) study examined data among a sample of boys between the ages of 10 and 15 culled from observational records charted 12 to 18 prior to their investigation. The researchers examined a number of variables ascertained from the records and generally sought to determine whether these variables differed among boys from home with or without a father present. They reported homosexuality did not differentiate between boys with fathers present and those with

absent fathers. However, methodological problems highlighted by the APA task force were evident from the start.

Attrition pared the original convenience sample of 325 down to 255. The final sample included 150 boys from intact families and only 55 who had father absent families with no randomization process in selecting these groups. Consequently, some of the cell sizes were very small. Nearly all dependent measures (e.g., “affectional interaction,” “homosexual tendencies”) were not clearly defined and where defined the terms used in these definitions were similarly vague. Moreover, no validity or reliability information was presented relative to these set of ratings that comprised variables such as homosexual tendencies. The relationship between homosexual tendencies and sexual orientation (a term never used in McCord, et al) is far from clear, even though the APA task force appears to assume they are commensurate. The sample was restricted to low SES boys. The article further does not make clear to what extent the researchers reviewing the records were aware of the study’s purposes.

Kurdek study. Kurdek (2004) compared longitudinal data obtained from gay and lesbian cohabiting couples and partners from heterosexual married couples with and without children, examining five domains of relationship health and determining if similar variables predicted relationship stability for these couples. Kurdek found that where differences between same-sex and heterosexual couples did exist, over two-thirds of these indicated gay and lesbian partners functioned better than heterosexual partners. The author concluded that the processes that regulate gay and lesbian relationships are the same as those that regulate heterosexual partners.

Methodological problems that, if consistently applied, would lead the APA task force to raise questions regarding Kurdek’s (2004) conclusions begin with his sampling procedures. Different methods were used to obtain the convenience samples of heterosexual and same-sex couples. Heterosexual couples were recruited through marriage announcements published in a daily newspaper. Same-sex couples were recruited through gay and lesbian periodicals, and these participants in turn were encouraged to recruit additional same-sex couples. Thus, selection and response bias may well have been a factor, especially in the recruitment and responses of same-sex participants. However, no measure of test-taking attitude was included that could have addressed this concern.

The longitudinal waves consisted of subsamples of participants, as attrition appeared to take a significant toll over the eight assessment periods. At first assessment, there were 80 heterosexual couples with children, but by the eighth assessment, only 50 remained. The *N* for heterosexual couples without parents declined from 146 to 29, gay couples decreased from 80 to 33, and lesbian couples diminished from 53 to 52. The sample was also restricted primarily to White and college educated individuals. The article did not present descriptive information for the correlational analyses that would permit evaluation of the extent to which univariate and multivariate assumptions had been met. Nor was the global evaluation outcome variable defined in a clear manner. In all instances, the variables studied were derived from self-report measures.

Other methodological concerns were evident in this research beyond those identified by the APA task force. While these will not be detailed for this analysis, one does bear mentioning in the present context. Specifically, Kurdek (2004) noted that same-sex couples were added to the sample at two points over the entire assessment

period, meaning gay and lesbian couples did not have the same number of possible assessments. This is reminiscent of the Jones and Yarhouse (2007) study of ex-gays, where the authors added to their sample of participants in religiously based SOCE. This sample addition was touted by critics as a serious methodological flaw that introduced bias into the research. While the two studies have different aims and foci, an equally applied methodological critique would certainly raise concerns about the bias that Kurdek might have introduced into his sample of same-sex couples by adding additional subjects after the initial assessment period.

Conclusion. Serious concerns about the APA task forces' objectivity have to be raised if this preliminary investigation is at all indicative of the methodological problems which exist in the literature cited uncritically to dismiss non-equivalency theories concerning sexual orientation etiology and relational functioning. Certainly in the present analysis of the McCord et al (1962) and Kurdek (2004) studies, had the task force applied their SOCE methodological critique with similar rigorousness, they would have been unable to cite these studies in any sort of generalized or conclusive manner. Yet such certainty is precisely what the APA task force seems to imply in their report. This disparate treatment of the SOCE literature in comparison to other sexual orientation research both reflects the lack of ideological diversity on the task force and the essential sociopolitical nature of the report. This, in turn, casts significant doubt upon the impartiality and accuracy of the APAs conclusions regarding SOCE.

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Table 1

Methodological Problems in the SOCE Research as Identified by the APA Task Force

Research Design	Problem
Experimental/ Quasi-Experimental Designs	Lack of comparison group/No treatment controls
	Lack of multiple baseline assessments
	No randomization to conditions
	Lack of multiple long term follow up assessments
	Significant sample attrition
	Retrospective pretests
All Designs	Lack a clear definition of terms
	Relies on self-report measures
	Relies on measures of unknown validity/reliability
	Participants not blind to study purposes
	Small sample size
	Violation of statistical assumptions
	Skewed distributions
	Narrow sample composition (e.g., homogeneity)
	Convenience sample (vs. population-based)
Recruiter/selection bias	

“The Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation”: Comments on its Problematic Legal Perspective.

Keith Vennum, Ph.D.

(Overall Summary) “Even though the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality,” Nothing in the report demonstrates that same-sex sexual and romantic attractions, feelings and behaviors are **positive**. Positive suggests they are in some way beneficial to an individual when in fact the report points out that such behaviors are often associated with **negative** mental health and physical health states and therefore one could accuse the APA of misleading confused or questioning individuals to negative mental or physical consequences by supporting their behaviors as positive. This opens the door for such an individual to bring a cause of action against the APA should they experience negative consequences from the same sex behavior much in the same way that cigarettes were once promoted as healthy by their manufacturers.

(Overall Summary last paragraph) The phrase “affirmative therapeutic interventions” is purposely unclear. All therapists want to be affirmative to their clients but in this case affirmative is not defined until (page 11 or 19 of 138) “This approach to psychotherapy is generally termed *affirmative, gay affirmative, or lesbian, gay, and bisexual (LGB) affirmative*.” By writing the report in this manner the phrase “gay affirming therapy” could be inserted where ever the word affirmative appears in the report. It is understood in this manner by LGBT therapists and those in the know but stops short of being open about the real agenda by hiding behind a universally accepted therapeutic principle.

(Executive Summary page viii or 10 of 138) “Same-sex sexual attractions, behavior, and orientations per se are normal and **positive** variants of human sexuality—in other words, they do not indicate either mental or developmental disorders.” The report provides no scientific data that same sex attractions, behavior, or orientations are positive so in this regard it is deceptive.

(Executive Summary or page viii or 10 of 138) “Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to

heterosexual relationships and families in **essential respects.**” The statement is deceptive since scientific evidence is clear that these relationships are anything but stable or committed when considered as a whole.

(page ii or 4 of 138) “APA reports synthesize current psychological knowledge in a given area and may offer recommendations for future action. They do not constitute APA policy or commit APA to the activities described therein.” This nice disclaimer I suppose relieves the APA from any liability associated with publishing this report. Should any suite be entered in regards to the report one of the settlement stipulations should be that this disclaimer be included with any published mention of APA’s stance on this area whether in print, visual, or aural media much like the Surgeon’s general warning on cigarette packs.

(page v or 7 of 138) “Thus, the appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients’ active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome.” The task force moves closer to limiting their definition of what affirmative therapy is including opening the door to the fact that a client may choose and a therapist may support changing the client’s sexual orientation identity as long as this is not a predetermined outcome for therapy on the part of the therapist.

(page viii or 10 of 138) “These studies show that enduring change to an individual’s sexual orientation is uncommon.” The task force admits that enduring change in sexual orientation in an individual is possible through psychotherapeutic efforts. (This is a good Public Relations bullet point)

(page viii or 10 of 138) “The review covered the peer-reviewed journal articles in English from 1960 to 2007 and included 83 studies.” Useful studies appear prior to 1960 and Jones and Yarhouse study which addressed the task force’s concerns appears after 2007. Why were these particular dates chosen if not to exclude relevant data?

(page ix or 11 of 138) “Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same sex attractions or increase other-sex sexual attractions through SOCE.” No references support this conclusion. What specific scientifically valid research indicates that individuals will not be able to change their attractions?

(page ix or 11 of 138) “recent SOCE research cannot provide conclusions regarding efficacy or safety.” The task force acknowledges that recent SOCE cannot be scientifically proven to be harmful to a significant number of individuals.

(page x or 12 of 138) “There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation.” The task force believes that providing therapy for children and adolescents will not impact their eventual sexual orientation so at best it won’t harm them in any way and at worst it will be a waste of time and money.

(page x or 12 of 138) “We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents. “

The task force provides no scientific study to document its concerns in this regard.

(page xi or 13 of 138) “The treatment does not differ, although the outcome of the client’s pathway to a sexual orientation identity does.” The task force acknowledges that good therapy may result in various outcomes for sexual orientation in individuals seeking change including a gay identity, a bisexual identity, or a heterosexual identity decided on by the client and one does not take any preeminence over the other.

(page xi or 13 of 138) “Other potential targets of treatment are emotional adjustment, including shame and self-stigma, and personal beliefs, values, and norms.” The task force believes that personal religious beliefs, religious values, and societal norms are legitimate targets for therapeutic change interventions.

(page xi or 13 of 138) “For instance, The clinical literature stresses interventions thatreduce internalized sexual stigma.” But the literature does not scientifically validate that such interventions are beneficial for the long term health of the client. Most of the literature stressing comes from gay affirmative literature and is conjectural in nature not scientifically validated.

(page xi or 13 of 138) “Additionally, the research and clinical literature **indicates** that increasing social support for sexual minority children and youth by intervening in schools and communities to increase their acceptance and safety is important.” There are no scientifically validated studies that support this premise.

(page xi or 13 of 138) “The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation.” The task force acknowledges that therapists should respect the importance and significance that faith holds for some clients.

(page xi or 13 of 138) Such psychotherapy can enhance clients’ search for meaning, significance, and a relationship with the sacred in their lives; increase positive religious coping; foster an understanding of religious motivations; help integrate religious and sexual orientation identities; and reframe sexual orientation identities to reduce self-

stigma.” The task force believes that therapists should figure out a way to reinterpret the revelation and teaching of the bible so that same sex attracted individuals can feel good about practicing a gay identity, remaining celibate, or claiming a heterosexual identity? To accomplish this requires some very complicated twisting of the truth presented in the bible.

(page xi or 13 of 138) “Licensed mental health providers strive to provide interventions that are consistent with current ethical standards. The APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) are resources for psychologists, especially Ethical Principles B (Benefit and Harm), D (Justice), and E (Respect for People’s Rights and Dignity, including self-determination). For instance, LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, **such as the evidence provided in this report** (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgment).” This statement elevates the report to the level of an ethical imperative something the task force specifically indicated in the verbal presentation at the APA meeting was not allowed by the APA where they said that they were not permitted to judge on ethical issues by the division of APA which normally sets APA ethical policy.

(page xi or 13 of 138) “LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.” This statement is useful for publicity since it indicates that religion must be given at least equal status with sexual orientation. It is interesting I am told that the Division 44 public meetings at the APA meeting with signs about diversity excluded religion in this list.

(page xi & xii or 13 & 14 of 138) Self-determination is the process by which a person controls or determines the course of her or his own life (according to the *Oxford American Dictionary*). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client’s assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. This suggest the possibility of a cause of action against any therapist that automatically uses a gay affirmative approach on a client who is unsure of how to proceed with their same sex attractions and has not yet decided that moving to a gay identity is the goal they would like to pursue. There have been recent reports of therapists being brought before professional bodies with actions against their license by clients who were gay activist in secret bating their therapists to use reparative therapy and then claiming harm. Nothing is to prevent a same sex attracted client with strong religious beliefs

from going to a notorious gay affirmative therapist and asking help with reconciling their religious beliefs and their same sex attraction. When the therapist launches into gay affirmative therapy without being assured that this is what the client desires a similar cause of action would seem open for the client with legal help to move against the therapists license using the task force report as evidence that the therapist was predetermining the goals of therapy. From a publicity standpoint it makes sense to announce to the world that therapists should not push a gay affirmative agenda on same sex religiously conflicted clients and this is supported by the APA task force report.

(page xii or 14 of 138) “Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has not provided evidence of efficacy, has the potential to be harmful, and delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. This is a largely nonsense statement since any new therapy is going to first have isolated reports of success before sufficient evidence has accumulated to prove efficacy and will carry the potential for being harmful until sufficient evidence accumulates to show that it is no more harmful than anything else therapists do. In what sense SOCE delegates diagnosis and type of therapy I cannot understand and the statement carries the implication that somehow therapists who practice SOCE are not qualified or possess no expertise.

(page xii or 14 of 138) “Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; and (e) include measures capable of assessing harm.” This presents the ideal for research but an impossible goal. One cannot generalize a population of individuals seeking SOCE nor address in a controlled fashion all preexisting and co-occurring conditions, mental health problems, other interventions and life histories so that progress in change is not confounded in some measure by them.

(page 8 or 16 of 138) In general this describes the process of forming the committee and suggest that it was open to the most qualified people but a verbal exchange between Douglas Haldeman at the presentation of the Task Force report at the APA convention confirmed that the selection of the task force was anything but open and that oppositional viewpoints were systematically excluded. The task force said nothing in response to Dr. Haldeman’s conjectures to discredit his characterization of the selection process thus giving tacit approval that it was correct.

(page 11 or 19 of 138) “3 We use the adjective *normal* to denote both the absence of a mental disorder and the presence of a positive and healthy outcome of human development.” Prostate cancer is normal for older men but certainly can’t be considered positive, same sex attraction is neither “normal” or “positive” it has an unusual or rare incidence in the population and is still considered unfortunate by the majority of the population.

(page 14 or 22 of 138) “(d) lesbians, gay men, and bisexual people can live satisfying lives and form stable, committed relationships and families that are equivalent to heterosexuals’ relationships and families in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007).” It would be interesting to see if the methodology applied to the scientific studies which support this conclusion are as rigorous as those that conclude sexual orientation does not change. I haven’t had time to read these studies but I would assume they generalize a few positive experiences in isolated cases to concluding that the same is true of the whole gay population. Although heterosexual couples currently are not in a good place I doubt that gay couples by any measure could be considered to be in an equal or better place. This is like saying that 1% of gay couples can live better than 20 % of heterosexual couples. It is a meaningless and deceptive comparison.

(page 14 or 22 of 138) “recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid.” This is a good publicity sound bite for our side in that we can say the APA task force acknowledges that sexual identity is fluid and can change.

(page 14 or 22 of 138) “EST are interventions for individuals with specific disorders that have been demonstrated as effective through rigorously controlled trials (Levant & Hasan, 2009)... We were not able to identify affirmative EST for this population (cf. Martell, Safran, & Prince, 2004). Could one ethically select from a population of individuals dissatisfied with their sexual orientation on religious grounds and assign one group to reparative therapy and the other group to gay affirmative therapy? Could one ethically select between individuals who dissatisfied with their sexual orientation apart from religious reasons and assign one group to reparative therapy and the other to gay affirmative therapy? Both propositions would violate client autonomy by forcing some religious individuals to go against their religious beliefs and some gay clients client autonomy would be violated by attempting to change their sexual orientation against their will. No EST trails as proposed will ever be performed as they are impossible to do.

(page 15 or 23 of 138) “We acknowledge that the model presented in this report would benefit from rigorous evaluation.” This also makes good publicity in that the task force admits that its model for therapy is conjectural and need scientific support.

(page 18 or 26 of 138) “16 These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how to live according to specific ethics and ideals (cf. Baumeister & Exline, 2000; Diener, 2000; Richards & Bergin, 2005; Schwartz, 2000).” A good publicity point the task force acknowledges that some individuals come to dislike their orientation apart from religious reasons.

(page 19 or 27 of 138) “The resolution affirms APA’s position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations.” Another publicity point the Task force acknowledges that religious beliefs in regards to homosexuality must be respected.

(page 23 or 31 of 138) “Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, & Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976).” I would like to review these studies. Were they subjected to the same scientific methodological rigor as those supporting change in sexual orientation?

Strong Recommendations by the APA Made in the Absence of “Adequate” Evidence.

David Wood, Ph.D.

If the authors’ conclusions regarding the inadequacy of evidence regarding the efficacy of sexual orientation change efforts are accepted, on what basis should the resulting recommendations be accepted? The normal course of action when inadequate evidence is available is to call for additional research and to refrain from making strong conclusions. This trend of making assertive recommendations in the absence of adequate data is applied to the evidence of harm as well as the issue of efficacy of those efforts. Evidence of harm is not strongly evident in the research reviewed and any conclusion that SOCE uniformly or highly likely to result in harm is unfounded. This is particularly problematic in light of the Report’s discussion of the perceived benefits and satisfaction with SOCE among some participants.

Differential regard for recent key studies on sexual orientation change efforts.

Two very important recent studies (Jones & Yarhouse, 2007; Spitzer, 2003) are treated only in a very cursory manner in the Report. Each of these studies appears to be utilized as a source of data regarding SOCE participant experiences as long as the experiences had nothing to do with sexual orientation change.

For instance, given the importance and methodological improvements of the Jones and Yarhouse study over some previous research efforts, it seems inadequate and even odd that the Task Force categorized it as inadequate alongside other studies with less rigor. Aside from some general reasons for exclusion listed in a footnote on page 90, the dismissive regard for this particular study seems particularly conspicuous in light of the study's prospective methodology. Of the approximately 16 references to Jones and Yarhouse (2003), the majority report participant experiences as long as the experienced had little or nothing to do with the participants' experience of sexual orientation change. The results of this particular study having to do with sexual orientation change were categorically dismissed.

Another instance of this differential regard of results reported is Spitzer (2003). Of the approximately 19 references to this study, descriptions of the sample predominated the discussion. Any mention of change was carefully worded as "perceived changes." The implicit effect is to suggest that participant perception of change reported in this study is to be categorically disregarded rather than carefully scrutinized for the strength and liabilities inherent in the study's design and results.

The general disdain of research on sexual-orientation change efforts.

An important part of the critique offered by the Report is that much of the literature on SOCE tends to appear in publications that are deemed of lesser credibility and influence. The implication is that the published literature suffers from poor methodological rigor and that this is the essential reason why these studies do not appear in the top-tier journals. What the Report author's fail to acknowledge is the strong bias and pervasive reluctance of journal editors to accept manuscripts on the topic unwanted same-sex sexual attraction or SOCE. Much of this reluctance appears to be fueled by fear or reprisals or negative "career repercussions" and "likely fallout" if one is to accept and publish studies in this controversial area (Jones and Yarhouse, 2003, pp 13-14). This reluctance is very real and potently results in few options for publication for studies in this area. The insistence that methodological rigor is the main reason why sexual orientation change studies appear in second tier or gray literature is incomplete and fails to recognize these biases.

APA Task Force Report -- a Mockery of Science

By Joseph Nicolosi, Ph.D.

The American Psychological Association (APA) has just released its “Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation” (August 2009), a report issued by five psychologists and one psychiatrist who are all activists in gay causes.

Remarkably, the APA rejected, for membership on this committee, every practitioner of sexual-reorientation therapy who applied for inclusion.

The rejected applicants included--

- NARTH Past-President A. Dean Byrd, Ph.D., M.P.H., M.B.A., a distinguished professor at the University of Utah School of Medicine, longtime practitioner of reorientation therapy, and co-author of several peer-reviewed journal articles studying change of sexual orientation. Dr. Byrd is considered one of the foremost experts on same-sex attraction and reorientation therapy. He has published numerous articles on sexual reorientation, as well as gender and parenting issues.
- George Rekers, Ph.D., Professor of Neuropsychiatry and Behavioral Science at the University of South Carolina, editor of the *Handbook of Child and Adolescent Sexual Problems*, a National Institute of Mental Health grant recipient, author of the book *Growing Up Straight*, as well as numerous peer-reviewed articles on gender-identity issues;
- Stanton Jones, Ph.D., Provost and Dean of the Graduate School and Professor of Psychology at Wheaton College, Illinois, the co-author of *Homosexuality: The Use Of Scientific Research In The Church's Moral Debate*.

- Joseph Nicolosi, Ph.D. (author of this article), a founder of NARTH, practitioner of reparative therapy for 25 years, and author of *Reparative Therapy of Male Homosexuality* and the 2009 book, *Shame and Attachment Loss*.
- Mark A. Yarhouse, Ph.D., is Professor of Psychology, Doctoral Program in Clinical Psychology at Regent University in Virginia Beach, Virginia. Dr. Yarhouse is co-author of *Homosexuality: The Use Of Scientific Research In The Church's Moral Debate* and has published many peer-reviewed articles on homosexuality.

When Clinton Anderson, Chairperson of the Task Force was confronted at an APA Town Hall Meeting as to why the above names were rejected, Dr. Anderson said: “they were not rejected, they just were not accepted.”

All of these highly qualified candidates were rejected. Instead, the following individuals were appointed:

Chair: Judith M. Glassgold, Psy.D. She sits on the board of the *Journal of Gay and Lesbian Psychotherapy* and is past president of APA’s Gay and Lesbian Division 44.

Jack Drescher, M.D., well-known as a gay-activist psychiatrist, serves on the *Journal of Gay and Lesbian Psychotherapy* and is one of the most vocal opponents of reparative therapy.

A. Lee Beckstead, Ph.D., is a counseling psychologist who counsels LBBT-oriented clients from traditional religious backgrounds. He is a staff associate at the University of Utah's Counseling Center and although he believes reorientation therapy can sometimes be helpful, he has expressed strong skepticism, and has urged the Mormon Church to revise its policy on homosexuality and instead, affirm church members who believe homosexuality reflects their true identity.

Beverly Greene, Ph.D., ABPP, was the founding co-editor of the APA Division 44 (gay and lesbian division) series, *Psychological Perspectives on Lesbian, Gay, and Bisexual Issues*.

Robin Lin Miller, Ph.D., is a community psychologist and associate professor at Michigan State University. From 1990-1995, she worked for the Gay Men's Health Crisis in New York City and has written for gay publications.

Roger L. Worthington, Ph.D., is the interim Chief Diversity Officer at the University of Missouri-Columbia. In 2001 he was awarded the "2001 Catalyst Award," from the LGBT Resource Center, University of Missouri, Columbia, for "speaking up and out and often regarding LGBT issues." He co-authored "Becoming an LGBT-Affirmative Career Advisor: Guidelines for Faculty, Staff, and Administrators" for the National Consortium of Directors of Lesbian Gay Bisexual and Transgender Resources in Higher Education.

Why a Gay Identity Obstructs Objectivity

The fact that the Task Force was composed entirely of activists in gay causes, most of whom are also personally gay, goes a long way toward explaining their failure to be scientifically objective.

To be “gay-identified” means to have undergone a counter-cultural rite of passage. According to the coming-out literature, when a person accepts and integrates a gay identity, he must give up the hope of ever changing his feelings and fantasies. The process is as follows: the adolescent discovers his same-sex attraction; this causes him confusion, shame and guilt. He desperately hopes that he will somehow become straight so that he will fit in with his friends and family. However, he eventually comes to believe that he is gay, and in fact can never be otherwise. Therefore, he must accept his homosexuality in the face of social rejection, and find pride in his homoerotic desires as something good, desirable, natural, and (if he is a person of faith) a gift from his creator.

The majority of the Task Force members clearly underwent this same process of abandoning the hope that they could diminish their homosexuality and develop their heterosexual potential. Coming to the Task Force from this perspective, they would be strongly invested in discouraging others from having the opportunity to change -- i.e., “*If it did not work for me, then it cannot work for you.*”

Conducting the Task Force Study

As the basis of their report, the Task Force members say they reviewed several hundred studies which, over the past century, have found subjects who changed their sexual orientation from homosexual to heterosexual.

The published and peer-reviewed studies they considered are all in some way flawed, the committee concluded, and therefore constitute “insufficient evidence” of the possibility of change. As a result, psychologists are advised to avoid telling their clients they can change their feelings. (The committee does grant, however, that some people can and do change their sexual identity—their sense of “who they are”—and go on to live heterosexually functional lives.)

How could the committee have reached a conclusion that would so sweepingly dismiss decades of research evidence? Some of it was conducted by well-known and highly prestigious professionals, such as Irving Bieber, Charles Socarides, Houston MacIntosh, and Robert Spitzer-- the same psychiatrist who oversaw the removal of homosexuality in 1973 from the diagnostic manual.

It was Dr. Spitzer who concluded in his recent report (published thirty years later by a prestigious journal – the *Archives of Sexual Behavior*, Vol. 32, No. 5, October 2003, pp. 403-417):

“Many patients, provided with informed consent about the possibility that they will be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions.”

He adds, “[T]he ability to make such a choice should be considered fundamental to client autonomy and self-determination.”

Lack of Diversity Among Task Force Members

If the APA truly wished to study sexual orientation, they would have followed established scientific practice by choosing a balanced committee that included individuals with differing values and worldviews. Particularly, they would have selected clinicians who see the value of sexual-reorientation -- not just such therapy’s philosophical opponents.

Instead, they ‘turned the henhouse over to the foxes’ by selecting gay-activists members who are well-known for their disapproval of efforts on the part of other homosexual individuals to seek change. The committee prefaces their report by stating as “scientific fact” their view – which has not been scientifically demonstrated (and, which is as much a question of philosophy as of science) that homosexual attractions and behavior are no different from heterosexuality.

Why did the APA select *only* such individuals? Perhaps, in well-meaning ignorance, they thought only gay activists could be experts on homosexuality. Perhaps they were intimidated by the threat of “homophobia” if they invited reorientation therapists to participate.

The scientific bias of the Task Force is further evidenced by four facts:

- The Task Force failed to reveal the well-documented, far-higher level of pathology associated with a homosexual lifestyle. If they had truly been interested in science, they would have believed it their duty to warn the public about the psychological and medical health risks associated with homosexual and bisexual behavior. Their failure to advise the public about the risks not only betrays their lack of commitment to science, but prevents sexually confused young people from accurately assessing the choices available to them.
- Why do some people become homosexual? The reader of the Report might justifiably expect some discussion of the factors associated with the development of same-sex attractions. Instead, the Task Force failed to study the risk factors— instead, saying that it is a “scientific fact” that homosexuality is “as developmentally normal as heterosexuality.”

- The Task Force did not study individuals who reported treatment success. Even if (for the sake of argument) therapeutic change had been reported to be successful in *only one* case, then the committee should have asked, “What therapeutic methods brought about this change?” But since the Task Force considered change unnecessary and undesirable, they showed no interest in pursuing this avenue of investigation.
- The Task Force’s standard for successful treatment for unwanted homosexuality was far higher than that for any other psychological condition. What if they had studied treatment success for narcissism, borderline personality disorder, or alcohol/food/drug abuse? All of these conditions, like unwanted homosexuality, cannot be expected to resolve totally, and necessitate some degree of lifelong struggle. Many of these conditions are, in fact, notoriously resistant to treatment. Yet there is no debate about the usefulness of treatment for these conditions: psychologists continue to treat them, despite their uncertain outcomes.

Different Concepts of Wholeness

The Task Force moved on to address religious beliefs that conflict with the affirmation of homosexuality. They attempt to resolve this conflict through creating a false distinction.

Organismic Congruence. Their report says, “Affirmative and multicultural models of LGB psychology give priority to organismic congruence (i.e., living with a sense of wholeness in one’s experiential self)” (p. 18).

Telic Congruence. This applies to people of faith who do not wish to integrate their homosexuality; they are instead “living consistently within one’s valuative goals.”

This is a half-truth, and a deceptive distinction. It implies that persons striving to live a life consistent with their religious values must deny their true sexual selves. They will not experience organismic wholeness, self-awareness and mature development of their identity. These attributes are only possible, by their definition, for individuals who embrace, rather than reject, their same-sex attractions. Religious individuals seeking “valuative congruence” are assumed to experience instead a constriction of their true selves through a religiously imposed behavioral control.

This erroneous distinction (one that can only be made by persons who have never known the harmonious integration of religious teachings) misunderstands and offends persons belonging to traditional faiths.

Rather, the members of the Task Force need to understand that the person of traditional faith finds his biblically based values to be guides, signposts, and sources of inspiration that will guide him on his journey toward wholeness. He intuitively senses that they lead him toward *a rightly-gendered wholeness* which allows him to live his life in a manner congruent with his creator’s design.

This wholeness is satisfying, experiential, and deeply integrated into the person's being. It is achieved not by suppression, repression or denial--but by understanding homosexuality within the greater context of a mature religious wisdom that is integrated into a scientifically accurate psychology.

An Analysis of: American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.

James E. Phelan, APA Member

Summary: After a careful review of the 2009 APA Task Force's *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, several critical items have been noted and are provided here. In general, the task force has stated, and the APA has voted on a resolution that sexual orientation change efforts (SOCE) is not likely to change sexual orientation, and that the continued use of SOCE is inappropriate and cautions its use in the marketplace. They justify such statements based on the task force's review of a limited body literature which they have judged as poorly designed, with serious methodological problems. As a result, the original task force document has been peer reviewed by this APA author, and is found to contain serious problems, mostly dealing with bias and misrepresentations of the research, which has ethical, legal, and public health implications. Finally, while the task force suggests SOCE unlikely produces change in sexual orientation and can even be harmful evidence, their own review of the research reveals there is not sufficient evidence to say whether or not harm is a result of SOCE, or that sexual orientation can or can not be changed. So, for them to make public policy recommendations, based on evidence that is not definitive,

presents a serious problem to both the public and mental health profession. A call for legal review is warranted due to APA's bias, misleading the public, abuse of authority, and for having a direct barring impact on clients' rights to self-determination and choices of services in the free and open market place in the United States of America.

The American Psychological Association (APA), a USA-based organization with approximately 150,000 members, via a hand-picked 6-member committee by then APA President, Dr. Sharon Stephens Brehm, titled, *APA Task Force on Appropriate Therapeutic responses to Sexual Orientation* reviewed 83 articles¹ dealing with sexual orientation change efforts (SOCE) in English from 1960 to 2007, with most studies conducted before 1978. The report with proposed resolutions was released during the APA's 2009 annual convention in Toronto in a document titled *Report of the American Psychological Association Task Force on Appropriate Therapeutic responses to Sexual Orientation*. As a result, the task force resolutions were adopted by the APA's governing council. The following are several highlights of an analysis of the task force report (APA, 2009), resolutions (APA, 2009, Appendix A) and/or news release (APA Press Release, 2009):

1. A major problem of the aforementioned report was the task force authors (chosen by the APA in 2007), who were partisan agents with a clear objective. That was to dismiss SOCE and recommend policy against its further use. Prior to any charged research review, the appointed task force chair had already made her conclusions. This chair, Dr Judith M. Glassgold, was not an advocate of SOCE, in fact was a longstanding gay and lesbian activist, and knew very well of the criticisms of SOCE. This was clear by her earlier prolific published works and presentations. Along with other gay advocates, in a 2002 letter to the editor of the APA journal *Psychotherapy*, she stated, "...the literature advocating reorientation therapies has been criticized in numerous ways..." (Glassgold, Fitzgerald, & Haldeman, 2002, p. 376). However, at that time she said these criticisms "need to be addressed thoroughly by advocates of such therapies" (p. 376). But, when such persons applied to be part of the task force, they were not chosen. If Glassgold was sincere in her notion to have advocates address any criticisms or research flaws, she did not follow through with it. If the task force was to be fair, it would have been

1. See bullet #29.

bipartisan as well as balanced out with neutral agents. Instead, it was totally comprised of opponents of SOCE, even prior to the systemic review, the review for which they made their case to recommend SOCE not be used, and subsequent recommendation for public policy (Appendix A), and to be used by mental health organizations world wide (p. 89). The report is not a minor opinion piece; it was meant for worldwide distribution built with authority from the largest American organization of psychologists. As such, its' corresponding press release to the Associated Press (the largest media outsource available) disseminated the information from the report, thus sparking leading major newspapers world wide to headline their conclusions.

2. In their findings, the task force alleged few studies on SOCE could be considered methodologically sound. However, "few studies" do not support a case to dismiss further use of such efforts as they suggested in their report and recent press release (APA, Press Release, 2009).
3. They said no study systematically evaluated potential harm. Therefore, it can not be said that SOCE is harmful in general.
4. The authors stated that, "The entire population of people who seek SOCE is unknown because the studies have relied entirely on convenience samples" (p. 3). If the population was largely unknown then it seems premature to issue a press release which told mental health workers they should avoid telling clients that they can change their sexual orientation through therapy or other treatments.
5. The authors noted that, "...some [former participants in SOCE] perceived that they had benefited from SOCE ..." (p.3), and "...some [former participants in SOCE] perceived that they had been harmed [from SOCE]" (p.3). Therefore, there's no consensus. In addition, they admit the research was not adequate to determine these factors to begin with. However, they showed bias in their discussions. For example, they highlighted, "there is some evidence that such efforts [SOCE] cause harm" (p. 66), but then on the item of *benefit* they said, "We have found limited research evidence of benefits from SOCE" (p. 68).
6. They stated that because the research on SOCE had not adequately distinguish between *sexual orientation* and *sexual orientation identity* such research has obscured what actually can or cannot change in human

- sexuality (p. 3). If they do not know what can or cannot change, then why did they issue a press release which told mental health workers they should avoid telling clients that they can change their sexual orientation through therapy or other treatments? Why, in their report did they say, “sexual orientation identity –not sexual orientation-appears to change via psychotherapy, support groups, and life events” (p. 63)? These are critical questions the task force must address.
7. In one part of the report the author’s say, “Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity” (p. 29). However, in another part of the report they dichotomized *sexual identity* and *orientation*. *Sexual identity* was defined as a person's individual or group membership and affiliation, self-labeling, sexual values and behaviors. *Sexual orientation* was defined "as an individual's pattern of erotic, sexual, romantic and affectional arousal and desire for other persons on those person's gender and sex characteristics" (p. 11). They concluded that it is unlikely that one could change *orientation*, that changes occur only in *identity*; however, this neglected reports in the literature, and it differs from other definitions of *sexual orientation*, for example, *sexual orientation* according to Farlex Dictionary, is defined unitarily by, “The direction of one's sexual interest toward members of the same, opposite, or both sexes”. Therefore, with this definition, if one changes their “sexual interest”, they have changed their *sexual orientation*. Above all this is the fact that the task force defined *sexual orientation*, either pre or post-review. It certainly was not clear, nor based on the review itself considering they alleged the studies reviewed were flawed due to construct validity (p. 29). In other words, the researchers neglected to adequately define, and subsequently, measure *sexual orientation*. Therefore, they constructed their own definition to satisfy their own agenda. This is not an appropriate action.
 8. The authors said that, “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” (p. 30). In an attempt to valid this statement they cited reports dated: 1948, 1953, 1979, 1995 and 1997. These dates do not indicate a period of “new understanding” considering that the last citation was over 12 year ago.
 9. While the task force stated that few forms of SOCE have not been subjected to “rigorous examination of efficacy and safety (p. 83), such

- comment could be made for other widely used types of psychotherapy, including Gay Affirmative Therapy (GAT). While the APA may support GAT or other affirmative processes, they too have not been subjected to rigorous study to evidence scientific efficacy.
10. Although they tell practitioners to not aim to alter sexual orientation, they tell researchers that since the research on SOCE, "has not adequately assessed efficacy and safety" (p. 6), that research on SOCE can go forward as long as it is done with "high-quality measures" (p. 6). This, therefore, takes the assumption that SOCE shall take place regardless of their position.
 11. The task forces' definition of *sexual orientation* is not the only problem surrounding definitions in the report. For example, *sexual minority* is a term they used to describe "the entire group of individuals who experience significant erotic and romantic attractions to *adult members* of their own sex..." (p. 1, emphasis added), yet they describe youth and adolescents as "sexual minorities". This is confusing since by their definition, the attractions of such "sexual minorities" are to members of one's own sex who are "adults".
 12. The report mentions *minority stress* and *sexual stigma* (p. 1) and claims that there is a "growing body of evidence concluding that sexual stigma" (p.1) directed at non-heterosexuals is responsible (see also p. 54). However, a recent study was conducted in an effort to find out what mechanisms (e.g. *minority stress*, environmental factors, genetic factors) might likely elevate psychiatric vulnerabilities of nonheterosexuals (admitting the latter has been the case). In conducting their literature review, they found some support for a "minority stress" hypothesis however such support was weakened by the fact that the relationship between sexual orientation and mental health is strong even in liberal countries, such as the Netherlands (Zietsch et al, 2009).
 13. The authors believe that *sexual minorities* benefit when they are taught to "overcome negative attitudes about themselves" (p. 13). The best form of treatment they feel is *gay-affirmative therapeutic interventions* (p. 13). This *sexual orientation stigma* or *internalized homophobia* is said to be a result of societal prejudices and discriminations. They argue that homosexuality is stigmatized (p. 14). There, they cite 2 reports by the same authors. In the report, the authors claim that one of the factors that

may lead on to SOCE is internalized stigma, however they go on to say “clients’ motivation to seek out and participate in SOCE seem to be complex” (p. 45), so therefore no real definitive statement can be made because they are admittedly not clear why. But, at any rate, they make this rapid claim.

14. The report alleged that the studies reviewed showed "enduring changes to the individual's sexual orientation [was] uncommon" (p. 2), and “unlikely” (p. 63) however they stated that the majority of the studies were not longitudinal studies. If the studies were not longitudinal, then it could not be concluded that enduring changes were uncommon. Instead of saying they were not uncommon in the general sense they should have said they were not studied in the larger sense.
15. The task force admitted that the field of psychoanalysis (along with behavior therapy) was most associated with the published literature on SOCE; psychoanalytic literature was published chiefly during the 1950s and 1960s (p. 11). They admitted that homosexuality treatment up until the first half of the 20th century was psychoanalytic in nature and “the dominate psychiatric paradigm” (p. 21) of that time. The current APA task Force however did not review and include this whole body of literature in their report. Rather, they created just one short paragraph titled “homosexuality and psychoanalysis” (p. 21) which largely discussed theory (which they dismissed as heterosexist) and not therapy. It shows bias on part of the authors to exclude reviews of psychoanalytic reports, especially the Bieber et al. (1962) study of patients who received treatment, and at the time, produced a methodological design which held quality research standards. In fact, at the time, it was the largest study available; however, the task force did not even include it in their systematic review of other older studies.
16. Rationales given for developing the new task force report: (a) "some APA members" believed the 1997 resolution needed to be reevaluated, mainly because it did not address questions of efficacy or safety of SOCE (p. 12). However, they never mention who these members were, how many, and in what format they addressed concerns; (b) "highly publicized research reports" of samples of individuals who had attempted sexual oriented changes were published and "other empirical and theoretical advances in the understanding of sexual orientation were published". However, of the papers cited, only one of the former would be considered highly publicized

- (Spitzer (2003)), and of the latter, a third of what was cited was published **after** the task force was formed; (c) Advocated asked for it. One named was "Truth Wins Out" which is solo operation, headed by a nonclinician, Mr. Wayne Besen who is known for being a gay-identified radical, who runs a blog which allows for derogatory language and sexual content, not suitable for youth (one population the APA feels it wants to benefit by the task forces' report), and definitely not scientific.
17. The authors cite 2 pieces (American Psychiatric Assoc, 1973, and Gonsiorek, 1991) as evidence that **"same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders"** (p. 14). These 2 reports are inadequate to be held as a basis for such disclaimer. The former, is not a scientific study, rather a statement. The latter was from a chapter in a book, for which the book chapter's author admitted the research was taken from faulty samples and poor designs. Besides, scholars have exclaimed, in a peer-reviewed research project on systemic review of research, that book chapters are not good evidence as they "...tend to not be peer-reviewed but rather invited" (Serovich, et al 2008, p. 229). Finally, in conducting their own systematic review of the research on SOCE, the authors of the current report, excluded studies that were not published in the format of a peer-reviewed scientific journal (p. 26).
 18. The authors claim *minority stress*, political opposition, and interpretations of traditional religious doctrines "...guide some efforts to change other's to change their sexual orientation..." (p. 17). However, this shows bias as they only include external factors of client's motivations, neglecting possible internal motivators, client's self-determination, and autonomy.
 19. As a point of note, the authors acknowledge that "difficulties arise because the psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, moral failing, or disorder that needs to be changed" (p. 18). This is also considered a "conflict" (p. 18) and when it arises the authors admit "quite complex" (p. 69).
 20. In their discussion of psychology, religion, and homosexuality, the authors discuss two philosophical concepts: *telic* (living consistently within one's valutive goals) and *organismic congruence* (living with a sense of

wholeness in one's experiential self). The authors' said, "Affirmative and multicultural models of LGB psychology give priority to organismic congruence" (p. 18). Whereas the *telic* concept would give priority to values (e.g. fundamental beliefs that homosexuality is immoral; disorder that needs to be changed). Although, they acknowledge *telic* concept as valid, and that differences remain (see # 19, above), they clearly demonstrate a favor bias to the *organismic congruence* concept. Also, problematic, and insensitive, is that traditionally religious individuals, with conservative, fundamental-belief systems, seeking valuative (*telic*) congruence are assumed to experience a constriction of their true selves through religiously imposed behavioral control. However, that disregards change elements experienced by many of these individuals, historically documented.

21. The authors stated that, "...although many religious individuals' desire to live their lives consistently with the values, primarily their religious values [*telic* congruence], we concluded that [that]...was unlikely to result in psychological well-being" (p. 55). They say this without any formal testing of *telic* and organismic congruence in the studies of SOCE. This is clear indication of the author's bias.
22. The report highlights clearly that APA views science and religion as separate and distinct. But, "faith does not need confirmation through scientific evidence" (p. 19), they said. The authors go on to say, "Further, science assumes some ideas can be rejected when proven false; faith and religious beliefs cannot be falsified in the eyes of adherents" (p. 19). In the final analysis, they point out that "faith traditions 'have no legitimate place arbitrating behavioral or other sciences'...or to 'adjudicate empirical scientific issues in psychology'" (p. 19). They say that they "take the perspective that religious faith and psychology do not have to be seen as opposed to each other" (p. 20) and there should be an "integrat[ion]" (p. 20) of both, yet clearly polarize the two by saying that religious faith has a back of the bus seat to psychology. So, how can they *not* be opposed? This is clearly a two-faced posture.
23. In a section, "Affirmative Approaches" (p. 22), to make their case that the theories that drove earlier SOCE were accumulated by evidence that yielded those theories "ill-founded" (p. 22), they cited three studies. One was the Kinsey Report (1948) which claimed that homosexuality was more "common" than thought. However, speaking of methodological factors,

that was certainly not a golden model. For one, some of the subjects were pedophiles in prisons. The other study cited was Ford and Beach (1951) which suggested that since homosexuality was observed in the animal kingdom it must be natural (See my earlier review of animal homosexuality, Phelan, 1998). And, finally they cite Hooker (1957), who used a small convenience sample, to make a case that homosexuals were no more pathological than heterosexuals, which has lost rigor.

24. They review the history of the removal of “homosexuality” from the DSM (p. 23). This has been critiqued already. They ignored the fact that this removal was for social-political reasons, not scientific. They merely briefly mentioned that it was escalated by the Stonewall riots. This again highlights the authors’ bias.
25. The whole basis of the task force report hinged on their review of research evidence of SOCE. However, in the section, “Sexual orientation change efforts provided to religious individuals” (p. 25) they point out that “recent studies” (p. 25) on SOCE included “almost exclusively individuals who [had] strong religious beliefs” (p. 25), included “a highly select[ed] group of people” (p. 28), and “composed almost exclusively of Caucasian males” (p. 33), however they failed to mention that in a sample of studies (1954-2004), 17 of which they reviewed, 82% did not even report the religion of participants and 79% did not report race (Serovich et al., 2008). In fact, Serovich et al (2008) concluded that there were so many omissions of demographics in studies of SOCE, it threatened the validity of interpreting the data.
26. A specific meta-analytic report, published in a peer-reviewed journal was excluded (p. 27), based on their own explanation that it deviated from standard meta-analytic protocol telling the reader to see 2 other reports for reasoning of such. However, one had nothing to do with the specific report, and the other was not even listed in the reference section. The latter a deviation in and of itself.
27. In a footnote to the overview of their systematic review, they say that they excluded one study based on it being published in 2008 (p. 27) after their review was completed *and* that it “appeared” to be a reworking of an earlier study by the same authors. If it “appeared” to be one thing, then this says they reviewed the study, at least in part, clearly showing partiality in its exclusion. If it were solely excluded on the factor of the publication

- date, that is one thing, but to say “and”, for another reason, it complicates matters. It so happened that the authors of the aforementioned study, as the one mentioned in the bullet above, were proponents of SOCE, so this clearly show the reviewers bias to exclude them. In addition, the authors managed to included other citations as late as 2009 in the writing of their report, so it is doubtful that it was too late to use a 2008 published study.
28. The task force report evidenced some neglect in providing references to citations; a few noted: Byrd, Nicolosi, & Potts (2008); Lipsey & Wilson (2001); McIntosh, 1990; Society for Prevention Research (2005). Without full reference, readers are unable to know what work they are referring to and therefore unable to verify the data. This would seem to have been caught in a rigorous peer-review process and editorial process for which the APA should have been at an advantage to receive.
 29. The authors said they reviewed 83 studies, providing an appendix which cites (N=83): (6 experimental, 3 quasi-experimental, 46 non-experimental). However, if you add up what they actually listed (see Appendix B, pp. 125-130), the number only equals 55. Again, if this was rigorously peer-reviewed, the reviewers would have caught such a huge discrepancy.
 30. The authors criticize the studies they reviewed on several basis, one being that that treatment samples had high drop out rates. However, other forms of treatments have high drop out rates (e.g. drug and alcohol treatments) yet the APA does not set up a task force to caution its use.
 31. The authors claim that “people will report change under circumstances in which they have been led to expect that change will occur...” (p. 29), however they do not provide any evidence to validate this statement.
 32. The authors admit that “external validity (generalization) of earlier studies is unclear” (p. 34), however they use these studies as a backdrop for their disclaimer that sexual orientation is not likely to change and that it should not be available in the marketplace.
 33. The authors reported that the studies they reviewed provided “some evidence of harm” (p. 35), however the majority of the studies were not conditioned to even measure harm, nor were they systematic or longitudinal for that research item. They seemed to show bias by

embracing this finding when other findings were dismissed under the notion that the studies were not held up “under the rigor of experimentation” (p. 35). Finally, the outcomes they discussed for the studies they reviewed gave blanket statements of random variety of symptoms of client’s reports. As the case with any study of treatment, the issues of side effects are never clearly known to be a product of the therapy itself, or due to other factors, since so many other factors occur simultaneously in a patient’s life, and could be possible explanations.

34. The authors, independent of the studies findings, defined sexual orientation “as an individual's pattern of erotic, sexual, romantic and affectional arousal and desire for other persons on those person's gender and sex characteristics (p. 29), however, in their systematic review of outcomes, they only reported on the items of *attractions*, *behaviors*, and *harm*. The items of “desire” and “romantic and affectal arousal” (assumed not necessity sexual, e.g. some people can be asexual, or sexually dysfunctional, castrated, etc), were not addressed. So, how can they make a statement that sexual orientation is unlikely to change when evidence has not been evaluated to satisfy their definition?
35. In their section of outcomes of “improving mental health” (p. 41), the authors failed to discussed what recent studies on the subject showed. They only discussed 3 studies from earlier research (1970-1972). This evidenced bias as they did discuss the harm items of recent studies.
36. The authors said, “[studies] provide no clear indication of the prevalence of harmful outcomes among people who have undergone [SOCE]” (p. 42) (this is because they found that no study to date was designed with adequate scientific rigor to measure such), but said that attempts to change “may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts” (p. 42). If no “clear indication” was found, how can they say attempts may cause distress?
37. The authors reported on twelve studies where anecdotal cases of harm was reported and they said, “we found that there was some evidence to indicate that individuals experience harm from SOCE” (p. 43)), but then they reported on at least 55 studies that looked at efficacy outcome of therapy, and where they also found evidence that some patients reduced same-sex attraction and behavior, they choose to discuss those outcomes

as “rare” and that “few studies provided strong evidence” (p. 43). The authors chose to show bias as they did not use the same language applied to SOCE as they did for the item of harm?

38. Participates in some recent studies reported beneficial effects such as a perceived change in their sexual orientation, even if this was distinct from scientific evaluation. The APA stated in their press release that “mental health professionals should avoid telling clients that they can change their sexual orientation through therapy or other treatments” and per other studies it “was unlikely to change”. They go on to say that certain studies suggested that some individuals learned how to ignore or not act on their homosexual attractions. Yet, these studies did not indicate for whom this was possible, how long it lasted or its long-term mental health effects. Also, this result was much less likely to be true for people who started out only attracted to people of the same sex.” While they choose to talk about “suggestions” of the latter, they failed to report the former, that being “Participates in some recent studies reported beneficial effects such as a perceived change in their sexual orientation”. This again, shows bias in reporting. Subsequent to their press release, major news papers made bold claims. For example, after receiving the press release, the *Los Angeles Times* headlined “Psychologists say sexual orientation can’t be changes through therapy”. While the APA may not be able to control how the media interprets it’s press release, it does state in their own code of ethics² that when their research is misinterpreted or misquoted, they have a responsibility to make attempts to correct the source. It remains to be seen if this has been done. At any rate, the damage is done, as millions of readers already accessed the *Los Angeles Times*, and have been exposed to this data.

39. In the task force report the authors admitted that “empirical supported treatments” are a common dilemma in psychology treatment (not just with homosexuality) and that they really based their recommendations not to use therapies aimed at changing orientation on “evidence-based approaches” (p. 14) available -- “the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 14). Actually, the arguments to use evidence-based

² According the the APA Code of Ethics: 8.10 Reporting Research Results:

(a) Psychologists do not fabricate data. (See also Standard [5.01a, Avoidance of False or Deceptive Statements](#).); (b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

- approaches is based on "current and best evidences" (p. 15), not science, per say, they added. They admitted they used a "flexible" (p. 15) concept of evidence. So, really they admitted they did not have an empirical bases for their position, just one that was "flexible" to what they wanted to say. So, why did they say studies such as Spitzer (2003) and Jones and Yarhouse (2007) were not "current [and] evidence" and dismiss what reparative therapists (clinical) experts are saying about their practices?
40. They task force allege that there are "no...peer-reviewed research that supports theories attributing sexual orientation to family dysfunction or trauma" (p. 54, emphasis added), however this ignores previous nonpartisan examinations of theories which counter such allegations (Fisher & Greenberg, 1977, 1996).
41. The authors presented a framework for affirmative therapeutic interventions which was based on "comprehensive review of the research and *clinical literature*" (p. 55, emphasis added), this again shows bias, because they did not consider clinical literature when making their final analysis about SOCE. For example, at least 34 psychoanalytic reports, of over 500 patients who had undergone SOCE exists which could have been reviewed, but were ignored.
42. If what the authors say, and their charge is taken literally, assessment of clients should see, "...the client's sexual orientation as part of the whole person and to develop interventions based on all significant variables" (p. 56), if indeed truly inclusive, would include SOCE, should clients desire it. The authors said, assessment could include various elements, one "understanding the specific religious beliefs of the client" (p. 56). For some clients, their religious belief is that God can change anything, this would include sexual orientation. The task force must be held accountable to their charge that awareness of religious issues is "important" (p. 57). After all, they admitted that, "[some] individuals reported that SOCE...helped them live in a manner consistent with their faith" (p.3).
43. In working with clients, the authors said it is "relevant" to use various therapy techniques, one being *dialectical behavior therapy*. However, this therapy also lacks rigorous longitudinal scientific research outcomes, the same reason that SOCE were criticized. This shows the authors' selective bias against SOCE.

44. The authors assume that those who seek SOCE will inherently suffer loss because what they desire (change in sexual orientation) will “not fit the individual’s predispositions” (p. 58). They say that the desire and actual ability to change is “irreconcilab[le]” (p. 58). They claim this will create the need for emotion-focused strategies to affirm sexual orientation identity. They say therapeutic outcomes include helping clients “com[e] to terms with...impossible selves” (p. 58). This assumes that homosexuality is inborn and therefore not changeable. This goes against the fact that there is no conclusive scientific evidence to say homosexuality is inborn.
45. In their framework for working with adults in affirmative intervention they suggest: “refocus clients on...more self-acceptance (assume to include the homosexuality)...than on their religion’s rejection of [the] homosexuality” (p. 59). They say to explore how to integrate the religion’s values with the client’s “sexuality” (p. 59). For some religions and individuals, this may create conflict, however. But, the task force prefers to focus on affirmation of the sexuality rather than on SOCE, or religious traditions or orders.
46. The task force admits that “participants reported benefits from mutual support groups, both sexual-minority affirming and ex-gay groups” (p. 59). This assumes it would be appropriate to refer to either. However, the task force again shows bias as in a footnote³ provided only resources for gay affirmative communities’ web links and none for ex-gay groups.
47. The task force report says that “...for clients whose...religi[on]...may...stigmatize their sexual identity...these clients may benefit from considering the alternative frame...[one that is] able to affirm their sexual orientation” (p.60). This was problematic in that it created groups to ask if clients should be told to switch churches. This has been addressed in post-media reports⁴, however an addendum is needed. This is also problematic in that it did not define what the possible “stigma” is; is it a religious element that is interpreted as stigmatic, or is it real? Is saying that homosexuality is a sin, or disordered, considered “stigma”? Whether this is real, or perceived, is not defined. Also, the bias is evident

³ Pg. 59

⁴ Throckmorton, W. (2009, Aug 21).

as it shifts the attention only to affirmation of sexual orientation and no other options, one being SOCE.

48. The task force says that one possible outcome of sexual orientation identity exploration (p. 60) is a “heterosexual sexual orientation identity” (p. 61). They also admit that “In some literature on SOCE, religious beliefs and identity are fixed, whereas sexual orientation is considered changeable” (p. 61). Therefore, they should not advise those who want to receive or provide SOCE, or sexual identity therapies, not to. This correlates with the APA code of ethics of respecting the client’s autonomy.
49. The authors stated that, “We encourage LMHP (Licensed Mental Health Professionals) to support clients in determining their own... behavioral expression of sexual orientation. If their *own* determination of *sexual expression* is unprotected anal sex with multiply partners then that should be encouraged? Even in light that research exists that unprotected anal sex with multiple partners is a public health problem? On the other hand, they will not say to encourage clients in determining their “own” *sexual orientation*, **only identity**. This again, shows clear bias.
50. The authors say that “research on the impact of heterosexism and traditional gender roles indicates that an individual’s adoption of traditional masculine norms increases sexual self-esteem and negatively affect mental health” (p. 62). They give one citation, from a study consisting of a convenience sample. This is not the same standard (rigorous research protocols) they call for in making their case against SOCE. Again, an illustration of bias.
51. They say that LMHP “address specific issues for religious clients” (p. 64) and this includes “spiritual functioning” (p. 64). However, in traditional faiths, the spirit of change is one aspect of dogma. But, in the report they don’t feel change of orientation is likely. This seems to be a conflict.
52. In a footnote on p. 65 the authors say that “Guidelines and standards for practice are created through a specific process that is outside the purview of the task force” (Footnote, p. 65). However in the conclusion of the same report made recommendation for public policy. The same task force was well aware that this report would be used for the APA to use as such, which was voted on at the same convention the report was released. The policy aspect was poised without scrutiny, as the task force itself was

- charged by the APA, membership of task force approved by the APA, and the policy aspect voted on by the APA. This was an inside job, with no objective or independent review.
53. The authors said it is, “inappropriate for psychologists and LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE” (p. 66), and that the greatest level of ethical concern was that such treatments were based on the presupposed notion that same-sex sexual orientation is a disorder or symptom of a disorder. They claim homosexuality is not a disorder based on “consensus” in research and by professionals. However a systemic review was not conducted to prove those ideas. To the contrary, a review of research does show that homosexuals in comparisons to heterosexuals do show greater pathology (Zietsch, 2009).
54. The task force, as well as the APA, assert that recommendations should be made when evidence is availed via research. In term of interventions with children, they say, “there is a lack of published research on SOCE among children” (p. 72), but dismiss psychotherapy in children which may alter adult sexual orientation because they feel sexual orientation does not emerge until puberty and that early childhood gender nonconformity does not necessarily subsequent adult homosexuality. Further, they say that interventions suggested to prevent homosexuality have been presented in non-peer-reviewed literature and conflate stereotypic gender roles, and should be avoided. They admit there is “no empirical research on adolescents who request SOCE” (p. 73), but yet warn not to use it.
55. The authors said that sexual orientation distress in adolescents is likely “in families for whom a religion that views homosexuality as sinful and undesirable is important” (p. 73), however this statement is not based on the rigorous research they call for in other areas. The task force again shows bias. In making a case that adolescents with an LGB identity face exclusion and rejection, they provide case studies as proof (e.g. Case, 2007) (p. 73), however they would not allow use of case studies when reviewing SOCE efficacy.
56. I agree with the task force where they say, that any inpatient admission for a child or adolescent be of the shortest possible duration and reserved for the most serious psychiatric illness. Adolescents should not be coerced into residential programs. Therefore I agree with the task forces

- recommendation that “LMHP should thrive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments” (p. 76).
57. The authors recommend that “LMHP support adolescents’ exploration of identity by accepting homosexuality and bisexuality as normal and positive variants of human sexual orientation” (p. 76). This is bias, however as it does not offer other alternatives, it merely says that one must accept homosexuality or bisexuality as the norm. (They admit that adolescents are in the mist of developmental processes in which the ultimate outcome is unknown” (p. 77)). In addition, it is not inclusive to those LMHP who do not see “homosexuality and bisexuality as normal and positive variants of human sexual orientation” (p. 76).
58. In the section on appropriate application of affirmative intervention with children and adolescents they recommend that LMHP provide “information and education” (p. 80) to LGB which will support them. As for parents, they “can be provided accurate information about sexual orientation” (p. 87). However, there is no mention that LMHP discuss, and parents be taught, the known dangers associated with the LGB population, in general. Most importantly, the scientific fact that since the inception of AIDS, gay men are at high risk for acquiring this disease. For example, the Centers for Disease Control (CDC) have consistently published evidence that gay men and other men who have sex with men (MSM) have AIDS at a rate much greater than women and non-gay/bi men. For a group so concerned about safety and welfare, this would seem so basic to the foundation of education vital to youth entering a high risk population, however it was totally omitted.
59. At one point in the report they said that information that stressed sexual orientation can be changed was based on “very limited empirical evidence” (p. 74), however they did not say “no evidence”, since this would indicate there is some evidence, then it would seem fair to not say it was “inappropriate” (p. 66), for professionals to provide SOCE to those who ask for it.
60. At the same 2009 APA convention where the task force released its report, another report was released - an extended longitudinal study (Jones & Yarhouse, 2009). The authors of that report, noted at a symposium that it was “[the] most rigorous longitudinal methodology ever

applied to [the] question of sexual orientation change and possible resulting harm". The conclusions stated that "the findings of this study would appear to contradict the commonly expressed view of the mental health establishment that sexual orientation is not changeable and that the attempt to change is highly likely to produce harm for those who make such an attempt". Given that this improved on methodology standards for which the task force has been critical of, the Jones and Yarhouse study therefore should be an addendum to the task forces' report. Finally, the report was endorsed by a former APA's president who was part of the symposium.

61. The task force emphasized that "...*there is some evidence that [SOCE] cause harm*" (p. 66), but then admits that "There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (p. 83). When it came to their discussion of the efficacy of SOCE they admitted "there is insufficient evidence that SOCE are efficacious for changing sexual orientation", but yet they make a definitive statement saying it would be "inappropriate" (p. 66) to use it. They said this, when in fact they knew that there was some evidence, although in their words it was "rare" (p. 83) and that "few" (p. 83) studies showed it. What they criticized then was the rigor of the studies, not the outcome. This is clear evidence of their bias, and betrayal of public trust.
62. The use of wording in the report clearly shows that they can not definitively say SOCE does not have efficacy or is harmful, so instead they say: "SOCE is *not likely* to produce its intended outcome" (p. 83, emphasis added) versus "SOCE *does not* produce its intended outcome"; and "can produce harm" (p. 83) versus "does produce harm".
63. The task force felt it okay to "expand beyond the scope of the systemic review" (p. 83) in order to develop an understanding of other areas around SOCE, however, they would not look beyond the scope of the systemic review to reveal the several psychoanalytic case studies that have show successful outcomes of SOCE over a 50 year span. This again, shows their bias.
64. To be honest, the only thing we can determine about one's sexual orientation is what we get subjectively. Some things can be objectively observed in the laboratory such as penile volume in response to sexual

stimulus. Other than that, we have to rely on subjective data. Both clients and clinicians have claimed complete reversals in sexual orientation, that from homosexuality to heterosexuality. This has been documented in the literature. In the current task force report, the authors make an unfounded claim: “Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice” (p. 84). This statement has not been tested scientifically and the studies that have looked at a biological origin of homosexuality are not conclusive. Therefore, this is gross misinformation to the public, and the APA should be charged for such misleading. It also goes against their own standards of presenting claims that are not backed by science.

65. The authors say that “the low degree of scientific rigor in [SOCE] studies makes any conclusions tentative” (p. 85). If “tentative” then why did they say that “sexual orientation is unlikely to change” (p. 84)? Why not, “we don’t know, from our interpretation of the limited research, that sexual orientation, can or can not change; any conclusion is tentative; we will need more research to make any definitive recommendations”?
66. In their summary of the task force report, the authors say “we found that religious individuals with beliefs that homosexuality is sinful and morally unacceptable are prominent in the population that currently undergoes SOCE” (p. 82). They then go on to say, “To respond as well as we could to this population we...recently adopted APA policies on religion and science...” (p. 82). If you look closer, the APA polices on religion and science has boldly stated that *intelligent design* (that which traditional faiths follows) is not scientific and that they only view *evolution* as scientifically valid (APA, 2008). They admit this “clashes” (p. 82) and say, “Psychology as a science and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints” (p. 82). However, they say this, yet they do not accept the religious beliefs at face values, saying that it is not scientific thereof not endorsed, in fact it is backseat to evolutionary theory, and recommend only gay affirmative responses. Therefore, they will not “respect” (p.82) any religion believing that homosexuality is sinful and morally unacceptable. This seems to contradict their statement on respecting different philosophical viewpoints.
However, the APA needs to be open to accepting the fact that some patients not only desire “spiritual healing” (Elkins, Marcus, Rajab, & Durgam, 2005, p. 234), but use it in their treatments for a variety of things

with various outcomes, and the data presented in an APA journal suggested that alternative therapies may play an important role in addition to standard psychotherapy practice (Elkins, et al. 2005). The authors claim that SOCE be avoided because “reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit and client’s development” (p. 87). But their citations for such disclaimer is based on limited research for which the same argument exists for which they base their disapproval of SOCE on – not longitudinal, flawed methodology, some are opinion pieces, outcome unable to be definitive, etc. Again, this shows bias.

67. I agree with the authors that “...LMHP working with clients seeking SOCE obtain additional knowledge and skills...” (p. 88). This knowledge base should also be inclusive of religion and respect for religion regardless if it is seen as “scientific” or not (this will help “...reduce their potential biases...” (p. 88)), client’s autonomy and rights to choose SOCE, and **all** theories of sexual orientation. Again, to reduce “biases” (p. 88).
68. The author’s accuse the published literature on SOCE to have made “inappropriate conclusions drawn from data” (p. 90), and go into a discussion about how studies with social implications need to be held to high standards due to their potential to influence policymakers and the public, and that misleading information can have serious cost. But, the task force suggests SOCE unlikely produces change in sexual orientation and can even be harmful evidence, however, their own review of the research reveals there is not sufficient evidence to say whether or not harm is a result of SOCE, or that sexual orientation can not be changed. In fact they admit, “...**the research on SOCE...has not answered basic questions of whether or not it is safe or effective and for whom**” (p. 90) and “**There are no studies of adequate rigor to conclude whether or not recent SOCE do or do not work to change a person’s sexual orientation**” (p. 120). So, for them to make public policy recommendations, based on evidence that is not definitive, in and of itself presents a serious problem to both the public and the mental health profession. Case in point: Based on their own press release to the Associated Press, the *LA Times* said “Psychologists say sexual orientation can’t be changed through therapy” (*LA Times*, Aug, 5, 2009).
69. I agree with the task force where they say people in the field work together to “...improve our knowledge of sexuality, sexual orientation, and sexual

- orientation identity..." (p. 91), and that future research is conducted in improved ways.
70. The APA should listen to some of the task force's own recommendations on pg. 92 and hold them to the same standards that they seek in others – (e.g. don't distort and selectively use data to support your own agendas, disseminate accurate data, etc.).
71. Appendix A: Resolution: They made a recommendation to "resolve" that there is "insufficient evidence" (p. 121) to support the use of SOCE. This was based on their finding that "There are no studies of adequate rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation" (p. 120). However, this is bias, because if they say they can not condone it, based on this finding, they must also say they can not condemn it either. Because the fact is, based on the findings, they don't know either way. So, for them to go one way is clearly bias and unjust to the public.
72. As it turns, 12 resolutions recommended by the task force were approved by the APA. The resolution that says not to distort data and mislead public opinion (p. 122), they have already broken.
73. The APA's verdicts (sexual orientation is not likely to change, and therapy aimed at changed should be discouraged) is not based on proof beyond reasonable doubt and common sense after careful and impartial consideration of all the evidence. For one, they did not consider all the evidence and the evidence they choose to use, was admittedly flawed and inadequate. Additionally, the authors were partial to the case to begin with. This has potential to harm the public.
74. The APA and the APA task force, with its voted resolutions, should go under legal review for civil rights violations, for misleading the media, the public and the mental health arena, and by such actions impeding clients from receiving treatment and helping agents the right to provide treatment according to the clients' wishes and desires.

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NOTE: Any citation listed in the body of this text and not listed in the reference section can be found in American Psychological Association Press Release of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009): <http://www.apa.org/releases/therapeutic.html> or from this author. Thank you.

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

By Philip M. Sutton, Ph.D.

1. Arbitrary dismissal of the importance of evidence provided prior to the past 50 years.

In drafting its list of criteria for acceptable research designs for evaluating the effectiveness of sexual orientation change efforts (SOCE), the American Psychological Association Task Force (subsequently referred to as APA unless otherwise noted) applies post hoc criteria to discount the credibility of older studies and clinical reports of SOCE, i.e., case and qualitative studies, many with multiple subjects/clients/patients, which were reported in the professional and scientific literature. APA begins its evaluation of the most recent 50 years (i.e., latter half of the 20th century) of scientific efforts to document SOCE's effectiveness while ignoring the prior 75 years of reports, admittedly sparse in the latter 19th and earlier 20th century.

2. Misrepresentation of the basis for originally removing homosexuality from the DSM II (cf no. 3 below).

Prior to the 1973 and 1974 actions by the APA's, treatment of SSA was considered normative, effective for some, and- like all psychotherapeutic approaches- not generally harmful. No research showed it to be otherwise. What changed was the perceived and ascribed acceptability of diagnosing and treating homosexuality.

The 1973 and 1974 decisions were based on politics- not science, and certainly not on the conduct of new science which refuted old studies, or existing psychotherapeutic practice. Those who have written about this history, including pro-gay activists admit that no new research showing that homosexuality was a healthier than previously thought or actually could not be changed was used to justify the decision. Yet, these decisions by both APA are cited now as if they were proof for what they asserted.

3. Undocumented and I think erroneous (fraudulent?) claims to a *scientific basis* for the normality of homosexuality.

- On page 2, Task Force Report's *Executive Summary* asserts that the following are "*scientific facts*" (I do not quote all):

* "*Same-sex attractions, behavior, and orientations per se are normal and positive variants of human sexuality-in other words, they do not indicate either mental or developmental disorders* (p. 2, cf. pg. 54)."

*** The first Resolution reads similarly 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*”; while the second Resolution adds that 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*” (pg. 121).

* *Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects* (pg. 2).

* “*Affirmative approaches (to treating)...the distress surrounding sexual orientation...are based on **the evidence** that homosexuality is not a mental illness or disorder, which has **significant empirical foundation** (APA, 2000: Gonsiorek, 1991).*”

* “***There are no empirical studies or peer-reviewed research that support theories attributing same-sex sexual orientation to family dysfunction or trauma*** (long list of authors cited as evidence)” (pg. 54-55). Others can speak to this better- I am not confident that I know the etiology literature well enough- but even if “technically” true, such evidence does exist in significant amount of clinical reports and case studies.

The Introduction to the main document of the TFR opens with reference to “the basis of emerging scientific evidence” and “on the growing scientific evidence” (citing Gonsiorek, 1991) as rationales removal of “homosexuality” from the DSM-II, “that homosexuality per se is not a mental disorder” and that diagnosing and treating it as such perpetuated a “stigma of mental illness that the medical and mental health professions had previously placed on sexual minorities” This “*emerging [and]...growing scientific evidence* also led to the acceptance by “*licensed mental health providers of all professions ...that homosexuality per se is a normal variant of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation* (pg. 11).

*****There is no “empirical foundation,” or “emerging or growing scientific evidence” for these assertions of which I am aware, short of gay activist mental health professionals and researchers asserting that they are true. The 1973 & 1974 decisions (i.e., political votes) by the APA’s seem to provide self-serving proof, i.e. a circular argument: the APA’s wouldn’t have said so if they weren’t true, and they’re true because the APA’s have said so.**

4. **The criteria for empirical acceptability are inconsistently applied.** None of the studies cited in support of the Task Forces “scientific facts” (pg. 2) meet their own stringent criteria (summarized on pg. 6; cf. pg. 21-22; 26-34; 42-43; 90-91). Also, as they

apply and require them, the criteria regarding sampling and control groups should and could not ever be met in a clinically responsible way.

- Ironically, the 2007 study by Jones and Yarhouse, which clearly is the most rigorous study of “SOCE” to date, is *not* mentioned in Chapter 4 which purports to be “A Systematic Review of Research on the Efficacy of SOCE: Outcomes”. In footnotes, this study is included with others as being unable to “access whether actual sexual orientation change occurred...due to their methodological issues” (pg. 44). A lengthier footnote (pg. 90) criticizes in detail the “study’s methodological problems”, yet a fair reading of the 2007 study and the three year additional followup reported at the 2009 APA convention in Toronto clearly shows that the four of five key criteria emphasized in this Task Force Report (pg. 6) were, in fact met, and that the criteria concerning sampling and control groups could not and should not have been met. If a demonstrably empirically sound study like Jones and Yarhouse’s yields results that are “unpersuasive” (pg. 90), then no further study could be persuasive. The Task Force has set the bar so artificially high that no study done in a clinically, as well as scientifically, responsible manner ever would be good enough.
- Ironically, the criteria insisted on by the Task Force could not be met by themselves. One would have to believe in the possibility and goodness of sexual orientation change as well as in the effectiveness of particular approaches to helping clients achieve such change. The way that the Task Force insists research be done would preclude either it’s ever being done- or ever good enough.

5. Two resolutions appear to accuse the likes of NARTH and religiously-mediated ministries for the very practices which the Task Force and others of their ilk themselves practice.

- 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*” (pg. 122)
- 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*” (pg. 122).

6. Spurious or novel – and non-empirically- supported distinctions obscure rather than clarify the lived realities of the lives of those with homosexual attractions and behaviors.

- *Sexual orientation vs. sexual orientation identity*: The Task Force Report attempts to identify an objective phenomenon (orientation) vs. a subjective (identity). “Orientation” is defined as an unchangeable characteristic while “identity” is changeable. Yet, the Report also admits as a “psychological fact” that for some people *sexual orientation identity*- but not orientation itself- is “fluid”. Pseudo-

science, i.e., at best conjecture with no objective way of clarifying someone's orientation (i.e., real self) from their self-reported identity (i.e., "individual or group membership or affiliation, self labeling", pg. 2).

Clients have and do report satisfaction with efforts to change their "sexual orientation." How you define sexual orientation affects how you measure and attempt to change this phenomenon. The fact that a person who is functionally free of homosexual obsessions and compulsions but who occasionally experiences homosexual attractions – not to mention if s/he has become functionally heterosexual in attractions and behaviors, at least to or with one's heterosexual partner- will have been helped or not depending on the "strict definition of sexual orientation.

Finally, the Report defines "sexual orientation" as "*an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics*" and states that "*orientation is tied to **physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings***" (pg. 30; cf. its definition of "sexual orientation identity"). While it can be acknowledged that persons typically don't choose to develop such physiological drives, arousals, desires, etc., the latest neuro-bio-psycho-social research reveals the "plasticity" and "learnability" of "physiological drives, arousals, desires, etc.", not to mention any behavior habits of gratifying or expressing them. It is difficult to believe how naïve the writers of this section could be.

- *Telic congruence* ("personal or religious values", i.e., "making commitments and decisions about how to live according to specific ethics and ideals") vs. *organismic congruence* ("i.e., living with a sense of wholeness in one's experiential self" which "would give priority to the development of self-awareness and identity." While the Report acknowledges "that the organismic worldview can be congruent with and respectful of religion", the Report's discussion seems to imply that while it is "OK" to have or seek "telic congruence, organismic congruence is of greater importance. While the Report does explicitly voice for the importance of respecting religious values, it strikes me as being more slick "lip service". A more careful read and analysis of the Report's treatment of "congruence" is warranted.

7. The discussion of the "stigma model" (pg. 15-17) fails to acknowledge that the most current research documenting the greater prevalence of medical, psychological and relational disorders among practicing homosexuals fails to support this hypothesis (cf. Section 3, Volume 1 (2009), *Journal of Human Sexuality*).

8. The Report engages in misdirection and inconsistent criticism. While emphasizing the importance for current outcome research to meet modern criteria for evidenced-based psychotherapy and declaring that attempts to document SOCE do not meet them and that its own model of affirmative therapy is in need of empirical validation, the Task Force asserts that reported benefits to clients who have engaged in SOCE are similar to those found by persons who are homosexual who sought therapy for other reasons, and therefore the (gay) affirmative approaches are valid but the SOCE are not.

9. APA is unjustifiably mischaracterizing a process with which many clients consumers are satisfied and for which they are grateful, and thereby stigmatizing the practice of therapists who provide such care, in claiming in its press release: *INSUFFICIENT EVIDENCE THAT SEXUAL ORIENTATION CHANGE EFFORTS WORK, SAYS APA* that “Practitioners Should Avoid Telling Clients They Can Change from Gay to Straight” (APA, 2009, <http://www.apa.org/releases/therapeutic.html>).

Final Note: I end here, not because I think I have commented on all that needs to be said of the Task Force Report, but because I have no more time at present to review this document. It will be important to actually review the cited references to assure that they actually say what the Report claims that the references say. Also, there are points of agreement with NARTH positions in the Report that I have not mentioned in this analysis. Keith Vennum’s e-mail sent on the NARTH List-Serv from/during the APA convention.