

**A Critical Evaluation of the *Report of the Task Force on  
Appropriate Therapeutic Responses to Sexual Orientation,*  
Resolutions, and Press Release**

James E. Phelan, Arthur Goldberg, and Christopher Doyle<sup>1</sup>

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<sup>1</sup> James E. Phelan, MSW, PsyD, is a licensed, board-certified clinical social worker, certified addictions counselor, and author. Arthur Goldberg, JD, is cofounder and codirector of JONAH, Jews Offering New Alternatives to Healing; president of PATH, Positive Alternatives to Homosexuality, a coalition of secular and faith-based organizations; and author of *Light in the Closet: Torah, Homosexuality, and the Power to Change*. Christopher Doyle, MA, is a clinical professional counselor resident with the International Healing Foundation and director of Acception Productions, LLC. He is the author of several publications on adolescent sexual health, including *Acception: Bullying Solutions and Prevention Health Education Curriculum*, *Benefits of Delaying Sexual Debut*, and *Benefits of Delaying Sexual Debut—Africa*.

## **Abstract**

The American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation reviewed the research literature pertaining to sexual orientation change efforts (SOCE) and concluded that the studies were either poorly designed or contained serious methodological flaws and lacked empirical rigor. Based on the task force report, the APA issued resolutions for appropriate affirmative responses to sexual orientation change efforts, and the resolutions were then followed by a press release. In this critical evaluation, we discuss the APA task force report, resolutions, and press release in the context of a methodological, clinical, and ethical framework.

## **Introduction**

The American Psychological Association (APA), an influential organization comprised of approximately 150,000 members, asked a six-member committee—the APA on Appropriate Therapeutic Responses to Sexual Orientation—to review selected research articles dealing with sexual orientation change efforts (SOCE) that were published in English between 1960 and 2007.

The task force report—titled *report of the American Psychological Association on Appropriate Therapeutic Responses to Sexual Orientation*—along with proposed resolutions, was released during the APA’s 2009 annual convention in Toronto, Canada. It was adopted by the APA’s governing Council of Representatives by a vote of 125–4 (Crary, 2009). A press release was subsequently disseminated worldwide via the Associated Press (APA Press Release, 2009).

This paper presents our critical evaluation of the findings of the task force report (APA, 2009), resolutions (APA, 2009, Appendix A), and press release/media coverage (APA Press Release, 2009; Crary, 2009; and Maugh, 2009) in the context of a methodological, clinical, and ethical framework.

## **Methodological Contexts**

In reviewing and evaluating the task force report, some methodological concerns became apparent. One of the task force’s principal rationales for the creation of the report was that “some APA members” (p. 12) believed a previous resolution (APA, 1998) needed to be reevaluated, mainly because it did not address questions regarding SOCE efficacy or safety. Unfortunately, the report never mentioned who these members were, how many there were, and in what format they addressed such concerns. Most importantly, if questions of efficacy and safety were to be answered in the present tense, then it would seem more appropriate if they had conducted a controlled research study testing efficacy and safety rather than a review of literature.

The task force interpreted SOCE studies as relying “almost exclusively of individuals who [had] strong religious beliefs” (p. 25), “a highly select[ed] group of people” (p. 28), and “composed almost exclusively of Caucasian males” (p. 33). However, in examining published studies from 1954 to 2004, 17 of which the task force reviewed, 82% did not report the religion of participants and 79% did not report race (Serovich et al., 2008). Further, a systematic review of SOCE concluded that the numerous omissions of demographics in SOCE studies threatened the validity of interpreting the data (Serovich et al., 2008). It appears that the failure to point out the findings of Serovich and colleagues (2008) is a shortcoming of the task force report.

In a footnote to the overview of their review, the authors commented that they excluded a study by Byrd, Nicolosi, and Potts (2008), alleging it was published after the time their review was completed *and* that it appeared to be simply a reworking of an earlier study by the same authors. However, the latter statement assumes the task force reviewed the study, at least in part. It may be plausible to exclude the study solely on the factor of its publication date—but to subjectively describe it militates against the task force’s stated rationale. Interestingly, the task force authors managed to include other citations as late as 2009 in the writing of their report, so their statement that a 2008 report was too late raises doubts.

Another methodological concern is in the report’s allegation that SOCE studies showed that “enduring changes to the individual’s sexual orientation [was] uncommon” (p. 2) and “unlikely” (p. 63). However, by recognizing in the report that the majority of those studies were not longitudinal, it would appear premature to make a conclusion about “enduring changes.” A more appropriate conclusion would state that based on the studies the task force cited, no conclusion about enduring changes could be made.

The authors cite two pieces of literature, American Psychiatric Association (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” (APA, 2009, p. 14). However, the APA (1973) document was not a scientific study (Bayer, 1987), and the Gonsiorek (1991) citation came from a chapter in a book he coedited. Although Gonsiorek wrote an interesting article, his purpose was to point out earlier studies that he and his fellow authors judged as having faulty samples and poor design; he did not try to present new empirical research on that subject.

Furthermore, we note methodologically that Serovich and colleagues (2008) excluded *all* studies that were not published in a peer-reviewed scientific journal when she and her coauthors conducted a systematic review of research on SOCE. The task force was inconsistent on this point. Regrettably, it appears as though it picked and chose among the literature, which in and of itself represents a methodological flaw. Thus, it is fair to conclude that the task force did not uphold the same methodological standards it ascribed to its critique of SOCE.

### **Failure to Review and Report All Evidence**

The authors stated they reviewed “83 studies” (six experimental, three quasi-experimental, 46 nonexperimental); however, what they listed adds up to only 55 (APA, 2009, pp. 125–130). Additionally, some assertions made by the authors lack substantial support. For example, they claim that “people will report change under circumstances in which they have been led to expect that change will occur” (APA, 2009, p. 29). However, no evidence is presented to validate this statement. The report claims that “external validity (generalization) of earlier [SOCE] studies [was] unclear” (p. 34), but then asserts that these same studies indicate that sexual orientation was not likely to change. If the validity of such studies was “unclear,” it appears invalid to make an affirmative claim about actual therapeutic outcomes.

The APA task force was not able to say whether or not sexual orientation “can or cannot change” (p. 3) due to limited research and methodological flaws. It also said

that any conclusion was “tentative” (p. 44), that no studies could enable them to “make a definitive statement about whether recent SOCE is safe or harmful” (p. 83), and that more research is recommended to “improve our knowledge” (p. 90) about sexual orientation. If the conclusion is tentative and more research is needed, then it begs the question as to why the task force concludes that “sexual orientation is unlikely to change” (p. 84) or that fostering hope that sexual orientation could change was “inappropriate” (p. 66).

### **Inconsistent Application of Standards**

The task force claimed that there is “*no* [emphasis added] . . . peer-reviewed research that supports theories attributing sexual orientation to family dysfunction” (APA 2009, p. 54). It cited one study by McCord, McCord, and Thurber (1962) to repudiate the theory that sexual orientation was associated with family dysfunction. However, it disregarded several published reports that specifically correlate sexual orientation to family dysfunction, such as Bieber et al. (1962); Lung and Shu (2007); Seutter and Rovers (2004); Silverman, Kwawer, Wolitzky, and Coron (1973); Wadler (1998); and Wilson and Widom (2009). Rosik (2012) investigated whether the task force consistently applied the same standards to SOCE studies as it did for the majority of studies the report referenced regarding developmental theories of sexual orientation. Rosik concluded that the report’s standards were inconsistent and indeed contained many of the same methodological flaws that led the task force to dismiss SOCE research. In all fairness, the study by McCord, McCord, and Thurber (1962), which the task force used to repudiate the theory that sexual orientation was associated with family dysfunction, is no better methodologically than the studies they criticized as supportive to theories attributing sexual orientation to family dysfunction.

The task force also criticized SOCE studies on the grounds that the studies had high dropout rates. However, many treatment cohorts have high dropout rates; take, for example, a drug and alcohol treatment program (Polich, Armor, & Braiker, 1981). De-

spite the fact that other treatment programs also have high dropout rates, the APA does not caution against their efforts. As such, this inconsistency forces the reader to assume that the task force holds SOCE studies to higher standards than others.

Another example where the task force did not apply its research methodology standards consistently is their citation of Kurdek (2004) to support the essential similarity between gay, lesbian, and heterosexual couples. This study, which they used to justify their conclusion, committed eight—or 50%—of the methodological problems ascribed to SOCE studies (Rosik, 2012). Additionally, the authors stated that “research on the impact of heterosexism and traditional gender roles indicates that an individual’s adoption of traditional masculine norms increases sexual self-stigma and . . . negatively affect[s] mental health” (p. 62). To support this claim, they provided only one citation, and that study was based on a convenience sample. Again, this is not the same rigorous research standard they called for in their review of SOCE.

The task force informs the readers that the greatest level of ethical concern was that SOCE were based on the presupposed notion that same-sex sexual orientation is a disorder, a symptom of a disorder, or evidences greater underlying pathologies. Their claim that homosexuality was not a disorder and that those who were identified as homosexual did not evidence any greater pathologies than heterosexuals was based, they claimed, on consensus in research and by professionals. However, this conclusion was not supported by the same type of review of literature to which they subjected SOCE studies. In fact, research has shown that homosexuals, in comparison to heterosexuals, do show greater pathologies (Hughes, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001; Zietsch, Verweij, Bailey, Wright, & Martin, 2009).

The authors claim that sexual orientation distress in adolescents is likely found “in families for whom a religion that views homosexuality as sinful and undesirable is important” (APA 2009, p. 73), without providing any valid substantiation for this proposition. Once again, the lack of rigorous research is evident and contradicts the

standards they seek for SOCE studies. In supporting the claim that adolescents with a lesbian, gay, or bisexual identity faced exclusion and rejection, they provided case studies as proof (e.g., Cates, 2007), which is something they specifically rejected when reviewing SOCE efficacy.

### **Different Standards for *Gay Affirmative Approaches* than for SOCE**

In a section titled “Affirmative Approaches” (APA, 2009, p. 22), the task force authors asserted that the underlying theories driving SOCE were “ill-founded” (p. 22). In the attempt to prove its point, the task force cited three studies that were not methodologically sound. The first study was Kinsey, Pomeroy, and Martin (1948), a controversial research report that claimed homosexuality was more common and usual than originally thought at the time. However, this study contained some of the very flaws of which SOCE studies were accused. The samples in the study were not random, and the study also had limits due to the fact that some samples consisted of pedophiles.

The second study cited was Ford and Beach (1951), which suggested that because homosexual behavior was observed in the animal kingdom, it must be natural. Although homosexual behavior can indeed be found in the animal kingdom, it is not the rule, and when observed, is usually circumstantial (e.g., the result of domestication, misinterpretation, interrupted environments, etc.) (Phelan, 1998). The study by Ford and Beach is also limited because their definition of sexuality included only stimulation and excitation of the sexual organs. Additionally, the authors (who were not psychologists) admitted that they were not qualified to assign application of their findings to the field of human psychology. They indicated that the study was meant to discuss the relationship between ethology and anthropology, specific to that sample, and not meant to be generalized (Lyons & Lyons, 2004).

The third study cited—Hooker (1957)—is also flawed. Using only a small convenience sample, a limited amount of psychometrics, and no longitudinal follow up, Hooker



concluded that homosexuals were no more pathological than heterosexuals. However, Gonsiorek (1991), whom the APA cites in their report as reliant, found Hooker's study to be "seminal ... [and that] this research was so consistent in its lack of findings suggesting inherent psychopathology in homosexuality that researchers began moving on to other projects by the 1980s. Recent research has dropped off because the inherent pathology of homosexuality has been answered from a scientific point of view and has not been seen as requiring more research" (p. 132).

It is interesting that Gonsiorek, like the APA, sees Hooker's study as "scientific" and therefore dismisses further needs for research, and yet it has similar methodological flaws to what the APA assigned to SOCE. By contrast, in a reanalysis of the Hooker results, Schumm (2012) has discovered that Hooker actually found significant differences in test results and lifestyle choices between heterosexual and homosexual men. These results challenge the interpretations and uses of Hooker's study to attempt to justify the "no differences" hypothesis.

In sum, by citing these three studies, the task force authors use a double standard: They fault the research on SOCE based on perceived methodological flaws, yet cite studies with similar methodological flaws to support their own conclusions. The authors claimed to have presented a framework for *affirmative therapeutic interventions* [emphasis added] that were based on a "comprehensive review of the research and *clinical literature* [emphasis added]" (APA 2009). However, they chose to exclude clinical reports of sexual orientation change when considering their review of SOCE. In fact, they dismissed as inadequate at least 34 psychoanalytic reports, involving more than 500 patients who had undergone SOCE, even though they admitted that psychoanalysis (along with behavior therapy) was "the dominant psychiatric paradigm" (p. 21) of the first half of the twentieth century. They excluded reports of both clients and clinicians who noted complete reversals in sexual orientation (e.g., Bieber, et al., 1962; Caprio, 1954; Ellis, 1959; Gordon, 1930; Hadfield, 1966; Hatterer, 1970; MacIntosh, 1994; Ovesey, 1969; and Siegel, 1988).

## *A Critical Evaluation*

An apparent decision to promote *gay affirmative psychotherapy*, a specific form of psychotherapy that encourages same-sex attracted persons to accept and embrace homosexuality and that is opposed to SOCE, was evident throughout the report. Although the phrase *affirmative therapeutic interventions* (p. 1) was introduced early in the task force's report without a specific definition, it is not until page 11 that the authors state, "This approach to psychotherapy is generally termed affirmative, gay-affirmative, or lesbian, gay, and bisexual (LGB) affirmative" (p. 11). Therefore, the phrase *gay affirmative psychotherapy* should be inserted wherever the phrases *affirmative therapeutic interventions*, *affirmative approaches*, or *gay affirmative therapeutic interventions* are seen throughout the report.

While the task force contends that *gay affirmative therapy* [emphasis added] is supported "on the basis of *growing* scientific evidence" (p. 11) and believes it is the best form of treatment for those who present with same-sex sexual orientation conflicts, advocates of SOCE state very similar arguments as to why they favor SOCE. While the task force states that few forms of SOCE have been subjected to "rigorous examination of efficacy and safety" (p. 83), they do not demand a comparable standard for other widely used types of psychotherapy, specifically for the *gay affirmative psychotherapy* advocated by their report.

Their bias toward *gay affirmative psychotherapy* is transparent. The APA endorsed *gay affirmative psychotherapy* over that of SOCE a dozen years earlier (APA, 1998). In fact, the APA's prior guidelines for affirmative models were used as a reference in the formation of *The Handbook of Affirmative Psychotherapy with Lesbians and Gay Men* (Ritter & Terndrup, 2002). Thus, it appears there is a preference for *gay affirmative psychotherapy* rather than SOCE, which calls the task force's objectivity into question.

## **Clinical Contexts**

### **Clients' Autonomy and Right to Self-determination**

The task force authors first claimed that a factor leading people to seek SOCE was *internalized stigma* but then said that “clients’ motivation to seek out and participate in SOCE seems to be *complex* [emphasis added]” (p. 45). Even conceding the complexity of clients’ motivation, the task force gives little or no credence to clients’ desire to change sexual orientation, let alone sets the same standard to measure *internalized stigma* as it did to measure the efficacy and safety of SOCE. The task force goes so far as to suggest that interpretation of traditional religious doctrines even guides some SOCE. We noted that while the task force included external factors of client’s motivations, it neglected to consider possible internal motivators. An overt focus on external motivations without considerations to internal motivations is a slippery slope toward negating clients’ right to self-determination and autonomy.

The authors also admitted “participants reported benefits from mutual support groups, both sexual-minority affirming and ex-gay groups” (p. 59). If, as they state, benefit was reported in both types of support groups, and if indeed the task force was supportive of a client’s right to choose, logically the footnote on page 59 of the report would refer readers to both types of groups. However, in the footnote, the authors provided resources for only gay affirmative communities’ web links; they exclude web links for ex-gays’ sites.

While the authors state, “We encourage LMHP [licensed mental health professionals] to *support* [emphasis added] clients in determining their own . . . *behavioral expression* [emphasis added] of sexual orientation” (p. 62), they neglect to discuss what might be appropriate components of caution for clients whose *behavioral expression* may be potentially unsafe. Curiously, while encouraging a client’s behavioral expression of sexuality, the authors discourage clients from seeking SOCE. This is a disconnect—on

one hand, they support a client's choice to express his/her sexuality unconditionally, yet on the other hand they apparently seem to deny him/her support if he/she chooses SOCE.

The authors compound problems when discussing the safety and autonomy of adolescent clients. While they say that "adolescents are in the midst of developmental processes in which the ultimate outcome is unknown" (p. 77), they recommend that "LMHP support adolescents' exploration of identity by accepting homosexuality and bisexuality as *normal and positive* [emphasis added] variants of human sexual orientation" (p. 76). At the same time, however, the task force dismisses affirmative SOCE research by suggesting those studies were not scientific enough and accuses SOCE proponents of engaging in philosophical conclusions. However, the authors are engaging in the same offense of which they accuse SOCE proponents. For example, they use terms such as *normal* and *positive*, which are philosophical instead of scientifically operationalized.

In the section on appropriate application of affirmative intervention with children and adolescents, the authors recommend that LMHP provide "information and education" (APA 2009, p. 80) to LGB children to support them and that their parents "be provided accurate information about sexual orientation" (p. 87). Absent, however, is any mention that LMHP discuss, and parents be taught, the known high-risk dangers associated with many aspects of LGB sexual practices. Most glaring is the omission of the empirical fact that since the inception of AIDS, gay men are at high risk for acquiring this disease. For example, the Centers for Disease Control and Prevention (CDC) has consistently published evidence that gay men and other men who have sex with men (MSM) have HIV/AIDS at a rate much greater than nongay/nonbi men (Lansky, 2009). The task force says on one hand that it is concerned about safety and welfare, yet on the other hand it omits essential educational recommendations vital to youth entering a high-risk subgroup.

### **SOCE Efficacy**

In an effort to dismiss the efficacy of SOCE, the authors claimed information that stressed sexual orientation can be changed was based on “very limited empirical evidence” (p. 74). Their choice of language actually admits the existence of evidence, albeit what they perceived as limited. They had no substantive grounds on which to say “no evidence.” Interestingly and coincidentally, to the contrary of their conclusion—and at the same 2009 APA convention where the task force released its report (APA, 2009)—an extended longitudinal study by Jones and Yarhouse (2009) was also released. Jones and Yarhouse noted that they used the “most rigorous longitudinal methodology ever applied to [the] question of sexual orientation change and possible resulting harm” (p. 4) and concluded 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” (p. 12). Neither the task force resolution nor press release took note of this; at a minimum, this data should be included as an addendum to the task force report and to the media in like manner.

### **Definitional Problems**

*Sexual orientation identity* was defined in the report as what or how people label themselves, based on factors such as “individual or group affiliation” (p. 2), sexual values, and behaviors. In the report, the authors dichotomized *sexual orientation identity* and *sexual orientation* and concluded that it was unlikely that one could change *orientation*, and that changes occur only in *identity*. To support such a contention, the task force suggested that the SOCE research it studied did not adequately distinguish between *sexual orientation* and *sexual orientation identity* (even though SOCE research exists that distinguishes between three separate aspects of sexual orientation—attraction, conduct, and self-identification). The authors conclude that SOCE research “obscured what actu-

ally can or cannot change in human sexuality” (APA, 2009, p. 3). At a minimum, they concede that “sexual orientation identity—not sexual orientation—appears to change via psychotherapy, support groups, and life events” (p. 63). However, in spite of its own finding that the research is *obscured* (perhaps not properly distinguishing whether all indicators changed or only some), the task force issued a press release telling mental health workers to *avoid* telling clients that they can change their sexual orientation through therapy or other treatments (APA Press Release, 2009). Since the task force concludes that the research it reviewed made it difficult to find out what can or cannot change, it would seem more appropriate to *avoid* telling clients that they can *or* cannot change their sexual orientation through therapy or other treatments.

### **Sexual Minority Stress**

The task force described *sexual minorities* as “the entire group of individuals who experience significant erotic and romantic attractions to *adult members* [emphasis added] of their own sex” (p. 1). Although it uses the term *adult* in its definition, it describes youth and adolescents as *sexual minorities* in other areas of the report.

The report’s authors also claim “internalized homophobia”—in other words, *minority stress* and *sexual stigma* (p. 1)—as evidence for the psychiatric vulnerability to a wide variety of mental health issues seen among nonheterosexuals. The authors claim that there is a “growing body of evidence concluding that sexual stigma” (p. 1) directed at nonheterosexuals is primarily responsible for such harm (see also p. 54). However, this “evidence” does not adhere to the same research standards requested of SOCE, and what the authors do use to support their case is from *gay affirmative* resources, again displaying inconsistent application of standards.

In an effort to find out what mechanisms—*minority stress*, environmental factors, and/or genetic factors—may elevate psychiatric vulnerabilities among nonheterosexuals, Zietsch and colleagues (2009) also attempted to find support for a *minority stress* hypoth-

esis; however, the sexual stigma hypothesis was weakened by evidence of mental health issues even in liberal, gay-affirming countries, such as the Netherlands (Sandfort et al., 2001; Zietsch et al., 2009). In fact, some studies reveal that nonheterosexuals have higher rates of psychopathology when compared to heterosexuals, regardless of *minority stress* (Sandfort et al., 2001; Zietsch et al., 2009). There is also no conclusive evidence to support that society or other environmental factors are causal of *minority stress*.

## **Ethical Contexts**

According to the APA Ethical Principles, psychologists should refrain from taking on interests that impair their objectivity (APA, 2002). One of the task force's principle rationales for the creation of its report was that "Advocates [those who opposed SOCE (e.g., Drescher, 2003) and those who promoted SOCE (e.g., Nicolosi, 2003)] asked" for such a report (p. 12). However, when it came to assembling the task force, advocates who were preopposed to SOCE (i.e., Drescher, 2003; Glassgold, 2007) were actually chosen to be members of the task force, while no proponents of SOCE were chosen (Nicolosi, n.d.).

Although the authors said that "guidelines and standards for practice are created through a specific process that is *outside the purview* [emphasis added] of the Task Force" (APA, 2009, footnote, p. 65), they made recommendations for public policy. Despite their own principle to not overtly influence public affairs (Tyler, 1969), this has been a recent trend for the APA. In several recent cases the APA has directly advocated for legal and policy changes (APA, 1998, 2003, 2005, 2008a). The task force undoubtedly was well aware that its report would be used as such and would be voted on by the APA's governing Council of Representatives at its annual convention. In fact, the report's authors asked for such a resolution. The policy aspect was passed without much scrutiny. Likewise, it did not accomplish a survey of its own membership, the mental health profession, or the general population for approval/disapproval, nor was there an established review period for feedback, despite the fact that the voice of the APA's members is generally solicited

when the APA governance wishes to issue a major statement or resolution on behalf of the association (APA, n.d.).

### **False Pretensions about Sexual Orientation and Biology**

In the task force report, the authors make the claim that “sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice” (APA, 2009, p. 84); however, research that has tested biological origins of homosexuality is not definitive (Osmundson, 2011). The fact remains that any conclusive genetic causality for homosexuality has not been found (APA, 2008a). Such a pronouncement saying that sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice can be misinterpreted by the public and could potentially influence public policy, creating an ethical concern. Such a pronouncement also contradicts the APA’s own public-disseminated information regarding sexual orientation and etiology, which says:

There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles. (APA, 2008b, p. 2)

The APA task force authors *assume* that those who seek SOCE will inherently be harmed (see section below) because their desire to change sexual orientation will “not fit the individual’s predispositions” (APA 2009, p. 58). They further contend that a client’s desire and actual ability to change is “irreconcilab[le]” (p. 58) and argue that it creates the need



for emotion-focused strategies to *affirm* sexual orientation identity. The task force's solution is that therapeutic outcomes should include helping clients "com[e] to terms with the disappointments, losses, and dissonance between psychological and emotional needs and possible and impossible selves" (p. 58). Such a position appears to take an *a priori* assumption that homosexuality is inborn and therefore immutable—in truth, however, such a contention is unsupported and contradicts the task force's own statements. It is also not fully supported by other APA members (Cummings, 2010; Jones, Rosik, Williams, & Byrd, 2010)—and, according to the APA's own Ethical Principles, the APA should not make deceptive statements regarding research findings (APA, 2002).

### **Conclusions about Harm**

In their section on outcomes of "improving mental health" (APA 2009, p. 41), the authors fail to discuss those studies that demonstrate positive outcomes of SOCE. After discussing three studies from earlier research (1970–1972), the authors shift their attention to alleged *harm* from SOCE. However, by excluding numerous studies that evidence benefit rather than harm, they continue to demonstrate inconsistent standards.

The authors claim that SOCE should be avoided because "reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit a client's development" (APA 2009, p. 87). Such an opinion is based on limited research and interestingly employs the very same arguments for which they criticized SOCE studies: nonlongitudinal and flawed methodology, use of opinion pieces, inconclusive outcomes, and so forth.

The authors state that they found no study that systematically evaluated potential harm. Yet, they claim that SOCE "can produce *harm* [emphasis added]" (APA 2009, p. 83). Such claim is based on anecdotes. Conversely, as previously emphasized, they dismiss any anecdotal evidence for positive SOCE outcomes. The authors' own language sets forth an inconsistency, both in their conclusions as to evidence of perceived harm or benefit and in

their manner of presenting findings on this point. An example of a lack of consistency is seen when the report states that “some [former participants in SOCE] perceived that they had benefited from SOCE . . .” (APA, 2009, p. 3), while also stating that “some [former participants in SOCE] perceived that they had been harmed [from SOCE]” (p. 3). Although the evidence cited by the task force includes a random variety of symptoms taken from individual clients’ reports, the report categorically rejects SOCE studies that rely on individual self-reports of change. To present material in such a manner shows an assumptive bias, particularly when other findings of the same studies were dismissed under the notion that the results of the studies were not obtained through the rigor of true *experiment*.

The authors continually contradict themselves in this respect. For example, they say, “[studies] provide no clear indication of the prevalence of harmful outcomes among people who have undergone [SOCE]” (p. 42) due to inadequate designs, but then complete the thought by a statement that SOCE “may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts” (p. 42). If no “clear indication” about the prevalence of harmful outcomes was found and the studies were flawed, the conclusion of the authors that attempts may cause or exacerbate distress is flawed and presents ethical concerns. The use of language to precondition the reader to a desired conclusion of the task force is evident. Another example is where the task force authors discuss twelve studies in which anecdotal cases of harm were reported. They claim that “we found that there was *some* [emphasis added] evidence to indicate that individuals experience harm from SOCE” (APA, 2009, p. 43), but then they cite at least fifty-five studies where the evidence reportedly related to patients who reduced homosexuality. To buttress their conclusions, the authors describe these latter outcomes as “rare” and stated that “few studies provided strong evidence” (p. 43) of the efficacy of SOCE. Note the use of the word *some* to evidence harm from a lesser number of cases and the words *few* and *rare* to describe the greater number of cases that suggested benefit (e.g., “*some* evidence . . . harm” vs. “*few* studies . . . evidence . . . changes” [p. 43, emphasis added]).

## **The Role of Media**

Even though participants in some recent studies reported beneficial effects of SOCE, such as a perceived change in their sexual orientation, the APA stated in its press release that “mental health professionals should avoid telling clients that they can change their sexual orientation through therapy or other treatments” and that sexual orientation “was unlikely to change” (APA Press Release, 2009, p. 1). However, the APA claim is contraindicated by other reports that document sexual orientation change (Cummings, 2010; Hughes, 2006; Jones & Yarhouse, 2007, 2011; Phelan, Whitehead, & Sutton, 2009; and Throckmorton, 1998). The APA’s press release clearly leads to media fabrications. For example, after receiving the press release, the *Los Angeles Times* headlined: “Psychologists say sexual orientation *can’t* [emphasis added] be changed through therapy” (Maugh, 2009, n.p.). Note the use of the word *can’t*. While the APA cannot completely control how the media interpreted its press release, it does have an obligation to correct such errors. It states in its own Ethics Code that when its research is misinterpreted or misquoted, it should take reasonable steps to correct the misinterpretation (APA, 2002).

The task force states that research on SOCE *can go forward*, as long as it is done with “high-quality measures” (APA, 2009, p. 6). At the same time, the authors recommend that practitioners refrain from attempting to alter sexual orientation because they do not believe it is appropriate to foster expectations that SOCE works. However, this begs the question of how SOCE can meet research standards if the advice by the task force is designed to dissuade its practice.

The resolutions recommended by the task force and subsequently approved by the APA’s governing Council of Representatives—as well as subsequent reports in the news media—appear to contradict the APA’s own Ethics Code (APA, 2002). They also appear to contradict and the APA’s adopted Leona Tyler Principle (Tyler, 1969), which obligates the APA to support client self-determination and to not mislead the public with data that

supports bias agendas meant to persuade policy. In the context of the APA's Leona Tyler Principle, it is not only important to determine what science can or cannot say but that ethicality and diversity be abided (A. D. Byrd, as cited in Cummings, 2010). It is misleading when SOCE is painted as harmful in the absence of conclusive, randomized, comparison studies that prove otherwise. It is misleading to say sexual minority status is tied to biological systems that are beyond conscious choice, when in fact this has not been conclusively supported in the research.

Finally, the contexts of ethics need not be taken lightly when there are implications for influencing public policy and applied therapeutic changes.

## **Concluding Discussion**

The APA task force's sensitivity to put forth efforts to understand the studies relevant to SOCE are commendable. However, many concerns surfaced when we evaluated the report within the context of a methodological, clinical, and ethical framework. In sum, the task force did not consider all the relevant literature; they admit the population who sought SOCE is largely *unknown*; they utilize inconsistent standards; and the evidence they chose to use is no better than the evidence they use to discredit SOCE. They do not ascribe the same standards for SOCE—the need for strong empirical rigor—as they do for gay affirmative therapy, family dysfunction of sexual minorities, psychopathology of sexual minorities, and sexual minority stress.

Moreover, the task force admits that its report is not substantive enough to make any conclusive and definitive recommendations about the efficacy and safety of SOCE. Yet, the task force states that it would be inappropriate to recommend that LMHPs use SOCE, despite the APA's *Ethical Principles of Psychologists and Code of Conduct*, which states that psychologists should respect the rights of client self-determination (APA, 2002). We concur with a prior critique of the task force report that found the report problematic both in its overly scrupulous application of methodological rigor to the SOCE and

its failure to apply enough rigors to a number of other issues on which it touches (Jones et al., 2010; Rosik, 2012). It is not unusual that an APA task force report, albeit on a different subject matter, has been critiqued and fallen short when independently reviewed (Coleman, 2008).

The task force accuses the authors of literature dealing with SOCE to have made “inappropriate conclusions drawn from data” (p. 90), and it goes into a discussion about how studies with social implications need to be held to high standards due to their potential influence on policymakers and the public. It also says that misleading information can have serious costs. Yet this criticism mirrors the errors of the task force report. The task force issued a press release telling mental health workers they should *avoid* telling clients that they can change their sexual orientation through therapy or other treatments (APA Press Release, 2009). Since research has made it difficult to find out what can or cannot change, it would seem ethically appropriate to *avoid* telling clients whether they can or cannot change their sexual orientation through therapy or other treatments. Likewise, it would be appropriate to correct the media they have influenced to purport headlines that sexual orientation “can’t” change (Maugh, 2009). This approach would be more compatible to the APA’s Ethics Code (APA, 2002) and the APA’s adopted Leona Tyler Principle (Tyler, 1969), which obligate the APA to support client self-determination and to not mislead the public or persuade public policy.

While the task force suggested that SOCE is unlikely to produce change in sexual orientation and can even be harmful, its own review of the research revealed insufficient evidence to say whether or not harm resulted from SOCE—or even whether sexual orientation can or cannot be changed. In fact, it contended that “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). Thus, for the authors to make positional recommendations with policy implications based on evidence that they admit is

not definitive presents potential ethical problems for both the public and the mental health profession. Likewise, while they say studies that support SOCE lack adequate rigor, their support for gay affirmative approaches have not been tested with equal empirical rigor.

After a review of the research literature pertaining to SOCE, the task force concludes that those studies were either poorly designed or contained serious methodological flaws and lacked empirical rigor. As such, it recommends against SOCE in its published report. This seems to suggest a straw man argument: Since SOCE lacks adequate scientific rigor, it is therefore inadequate.

Further, because the resolutions come from an authoritative organization, they hold the risk of being perceived by lawmakers and state licensing boards as *policy* and therefore by proxy prescriptive to LMHP practice. A case in point is where the task force report is currently being used as a reference for proposed California Senate Bill 1172 that would ban psychotherapists from offering SOCE to clients under the age of eighteen, regardless of clients' and their parents' wishes. This bill states that "sexual orientation change efforts pose critical health risks," claiming—falsely—that the task force report supports this assertion (Senate Bill 1172, 2012, p. 1).<sup>1</sup>

Lawmakers and state licensing boards who use the task force findings as *policy*—and therefore by proxy prescriptive to LMHP practice—could potentially create legal entanglements for LMHP, particularly those who follow a conservative religious framework (DeBoer, 2009). Any *policy* based on the task force report that favors *gay affirming psychotherapy* while abandoning one that is more compatible with a conservative religious worldview will burden the prior religious practices of some and presents any potential *policy* as unconstitutional (DeBoer, 2009). What DeBoers (2009) means is that the true practice of free exercise will have to include "the incorporation of conscience"

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<sup>1</sup> Each time SB 1172 has come up for vote, both in committee and before the California Senate and Assembly, elements of the bill have changed. The key provision banning the practice of SOCE for minors has consistently remained. After having passed both houses of the California legislature, SB 1172 was enrolled on September 5, 2012, and was sent to the governor for authorization.

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(p. 430), and therefore clients will have “freedom to pursue [a] full range of counseling approaches, including change therapy or sexual identity therapy” (p. 430).

Finally, it is recommended that the APA task force report, with its voted resolutions and press release, be cautiously reviewed in light of our evaluation so as not to mislead the media, the public, and the mental health profession, and by such actions impede certain clients from receiving treatment respectful to their personal values and preferences.

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