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Introduction to Special Section:

A Backstory to the American Psychological Association's (2021) Resolution on Sexual Orientation Change Efforts

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Introduction

The American Psychological Association (APA), in 2019, was taking comments from its members on a proposed updated resolution in opposition to sexual orientation change efforts (SOCE) and a new resolution on gender identity change efforts (GICE). I learned of this late in that process and emailed Ron Schittler of Division 44, the division that focuses on sexuality and gender issues from a liberal perspective, requesting to see the proposed resolution and comment on it. He agreed to let me do so but said I would need to wait while APA's chief attorney vetted the final drafts. My recollection is that he said the resolutions, once vetted by APA's attorney, would be ready to go. I did wait, and he did send the vetted SOCE and GICE resolutions. He said he would have to receive my comment by the deadline of May 16, 2019.

On May 16, 2019, I emailed him a 99-page comment titled, "Comment on Proposed Updated APA Resolution on Sexual Orientation Change Efforts", addressed to the Div. 44 committees that authored the APA's SOCE and GICE resolutions. Also in this email were a comment by Michelle Cretella, MD, then president of the American College of Pediatricians, on the GICE resolution and a legislative analysis of the resolutions by attorney Mary McAllister who at the time was representing Liberty Counsel. Signatories to the email were APA members Christopher Rosik, Ph.D., David Pickup, LMFT, and myself (Laura Haynes, Ph.D.).

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I wrote the comment on the SOCE resolution from my own research and thoughts and from an expert testimony by Rosik that Liberty Counsel submitted as an expert witness in a winning legal case defending the right of minors to pursue change-exploring, speech-based therapies (Vazzo v. City of Tampa].

When we sent the comments, Ron Schittler, Assistant Director of the Sexual Orientation and Gender Diversity Portfolio at the APA, acknowledged receipt and thanked us for our thoroughness. So there the resolutions were, ready to go and expected to be published any day. But then they did not appear. People kept wondering where they were and what was holding them up. Finally, a different version was published in February 2021 (APA, 2021). We cannot know for certain whether our comments had an effect, but the publication of these documents may help toward filling in an unanswered question in American psychology history.

Below is the text of the email from Schittler dated April 23, 2019, which sets up the presentation of our submissions in this special section:

> Hello Dr. Haynes,
>
> The attached two proposed APA policy resolutions have just been sent to our Boards and Committees for review and comment by May 16. You are welcome to send me any comments you may have by that date also for consideration by the writing groups.
>
> Here was some short introductory material about each:
>
> SOCE:
>
> The proposed resolution was developed jointly by the Society for the Psychology of Sexual Orientation and Gender Diversity and the Committee on Sexual Orientation and Gender Diversity. It builds on Appropriate Therapeutic Responses to Sexual Orientation adopted in 1997 and Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts adopted in 2009, taking account of research that has been published since 2009 and recognizing the evolution of public and legislative attention to the issue.
>
> GICE:
>
> The proposed resolution was developed jointly by the Society for the Psychology of Sexual Orientation and Gender Diversity and the Committee on Sexual Orientation and Gender Diversity. The proposed policy resolution would be the first time APA has adopted policy on gender identity change efforts.
>
> Thank you for your interest.
>
> Ron

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APA's Proposed Gender Identity Change Efforts (GICE) Policy: A Ruse for Shutting Down Ethical Psychotherapy and Locking Youth into a Trans Identity

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In this brief submission to the American Psychological Association (APA), Michelle Cretella, M.D., outlines twelve key observations that suggest the American Psychological Association's attempt to update its resolution on gender identity change efforts (GICE) is misguided and dangerous.

Keywords: Gender Identity Change Efforts, GICE, American Psychological Association

1. The Association of American Physicians and Surgeons, the American College of Pediatricians, the Christian Medical Association, the Catholic Medical Association, the Alliance for Therapeutic Choice, the National Task Force for Therapy Equality, the American Association of Christian Counselors, and the Catholic Psychotherapy Association represent *over 70,000 health professionals who support therapeutically exploring incongruent childhood gender identities while providing alternative ways to ease dysphoria.* This contrasts sharply with the policy of the American Academy of Pediatrics (AAP), and with the APA's current policy that seems to move in the direction of affirming all gender incongruence without regard to underlying psycho-social factors or psychiatric history.

2. The American Academy of Pediatrics (AAP) recommends all children with gender dysphoria be affirmed regardless of age. This sends youth down an experimental medical pathway that converts their bodies into a facsimile of the opposite sex at great risk for long term harm.

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Renowned sexologist and child gender identity expert, Dr. James Cantor, therefore fact-checked the AAP policy (2018). He found "the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*."

3. The AAP, like the APA in this proposal, claims that "conversion therapy" has been proven harmful when applied to gender identity. This claim struck Dr. Cantor as odd, as it should all of us, since, as he writes "*there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation*—specifically, the sexual orientation *of adults*—not *gender identity*, and not *children* in any case"[emphasis in original].

4. Unlike skin color, the failure to identify with one's sex is not solely biologically determined; it resolves in a majority of children when they are supported through natural puberty, and has been known to remit even in adults (Cantor, 2016; Marks, et al., 2000).

5. At least sixteen case series document examples of successful identification with one's sex in adolescents and adults while undergoing psychotherapy. (See attachment)

6. Dr. Zucker and colleagues (2016) posited that since "GD can remit in some [adult]cases (Marks et al. 2000); perhaps psychotherapy could facilitate such remission – or a reduction in GD symptoms… [but] these possibilities have not yet been investigated, and such investigations are strongly discouraged."

7. In contrast to gender identity, sex is an innate and immutable biological trait. Sex is determined by genes at fertilization, declares itself physically and is recognized as unambiguous before or at birth 99.98% of the time (Sax, 2002).

8. The failure to identify with one's sex cannot be considered a "normative" human experience by any stretch of the imagination given its infinitesimally low incidence.

9. For gender incongruence to be considered an expression of mental health, sanity is no longer defined as having thoughts that align with material reality. This in and of itself is insane.

10. Gender incongruence is not healthy. It is associated with higher rates of mortality and comorbidities, including but not limited to bipolar disorder, PTSD and Axis I diagnoses. Hypothetically, these comorbidities may precipitate gender incongruence in certain vulnerable individuals.

11. The medicalization of gender incongruence is dangerous and has not been proven safe or effective in adults, let alone children. The Center for Medicare & Medicaid Services (n.d.) under the Obama administration conducted a comprehensive review of the scientific literature in 2016 and found that evidence for long term benefit from gender affirming surgeries and hormones is too weak and risk of significant harm too great for CMS to mandate that states cover these interventions.

12. Given the above facts, as the number of transition-regretters continues to grow, it is only a matter of time before health organizations like the AAP and APA will face lawsuits for daring to profit from the medicalization of identity politics at the expense of patients' lives.

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Comment on the Proposed Updated American Psychological Association's "Resolution on Sexual Orientation Change Efforts"

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In this extended comment on and review of relevant scientific literature submitted to the American Psychological Association (APA), Laura Haynes, Ph.D., and Christopher Rosik, Ph.D., address several central concerns with the APA's proposed updated resolution on sexual orientation change efforts (SOCE). These include: (1) the APA task force Report's (2009) claims regarding the safety and effectiveness of SOCE and psychological causes of same-sex sexuality, (2) recent SOCE research the Resolution references, (3) correction of one of the APA task force Report's "three key findings" that same-sex attraction is immutable on which it said it "built" its recommendations, (4) need for the APA to update the public that it has changed its view regarding the factors that may contribute to the development of same-sex attractions, (5) sexual attraction fluidity, willed choices that affect it, and change-allowing therapies, (6) stigma as a claimed primary explanation for health disparities or risky behavior in same-sex sexuality and SOCE as a proxy for stigma, (7) evidence that SOCE bans target professional speech and viewpoint, not aversive practices, (8) reasons people seek change-allowing therapies, and (9) religious discrimination underlying the Resolution. They conclude the approach taken by the proposed APA Resolution represents a perspective unacceptably bounded by ideology regarding SOCE and they provide recommendations to the APA and its committees for what they believe to be a better path.

Keywords: SOCE resolution, American Psychological Association, alternative scientific perspective

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Christopher H. Rosik, Ph.D., is a psychologist in Fresno, California, and past President and Chair of the Research Division of the Alliance for Therapeutic Choice and Scientific Integrity. He has published more than 60 articles in peer-reviewed journals and has made presentations across America and Europe.

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We are writing to comment on the "Resolution on Sexual Orientation Change Efforts" (SOCE) draft for review and comment by APA Boards and Committees developed jointly by the Society for the Psychology of Sexual Orientation and Gender Diversity and the Committee on Sexual Orientation and Gender Diversity. It is our understanding that the SOCE Resolution builds on "Appropriate Therapeutic Responses to Sexual Orientation" adopted in 1997 and "Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" adopted in 2009, taking account of research that has been published since 2009 and recognizing the evolution of public and legislative attention to the issue. The Resolution resolves that "there are serious ethical concerns about SOCE" and "that APA encourages psychologists to advocate for public policies and federal legislation aimed at ending SOCE." As APA members who support therapies that are open to meaningful shifts or changes in sexual attraction or behavior, we appreciate the opportunity to reply. We understand that "Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" adopted in 2009 was based on the "Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation" (2009). We will refer to the proposed updated resolution as the "Resolution" and to the "Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation" as the "Report."

We will address the following topics: (1) the APA task force Report's claims regarding the safety and effectiveness of SOCE and psychological causes of same-sex sexuality, (2) recent SOCE research the Resolution references, including the Ryan 2018 study, (3) correction of one of the APA task force Report's "three key findings" that same-sex attraction is immutable on which it said it "built" its recommendations, (4) need for the APA to update the public that it has changed from its view that same-sex sexuality is largely biologically determined and immutable and that the APA has acknowledged same-sex sexuality has "psychoanalytic" causes and "associative and potentially causal links" to childhood sexual abuse—by updating the APA's legal briefs on same-sex sexuality, by updating the APA's model of therapy for conflicts between same-sex sexuality and religious faith, and by updating the Resolution's proposed campaign to censor SOCE legally, (5) professional guild opinion and historical consensus of scientists—that it is unreliable, has partially reversed even during the recent decade, is ideologically biased, and is not scientific evidence, (6) sexual attraction fluidity, willed choices that affect it, and change-allowing therapies, (7) stigma as a claimed primary explanation for health disparities or risky behavior in same-sex sexuality and SOCE as a proxy for stigma, (8) evidence that SOCE bans target professional speech and viewpoint, not aversive practices, (9) reasons people seek change-allowing therapies, and (10) religious discrimination underlying the Resolution. We will conclude with recommendations to the APA and its committees for what we believe is a better path.

We note at the outset that the terminology of "sexual orientation change efforts" (SOCE) and "sexual orientation conversion therapy" or "conversion therapy" are in many ways misnomers. These terms imply that categorical change (from exclusive same-sex attraction to exclusive opposite sex attraction) is the goal and the focus, although change typically is on a continuum and can occur without a direct therapeutic focus on sexuality. SOCE also

is not clear about what constitutes an "effort" and whether this effort is that of the client and/or the therapist. However, ethical change-allowing talk therapies are client-directed and do not impose goals on the client. "Conversion therapy" gives the false impression to some that there is a singular exotic therapy being practiced when in fact, practitioners in this area utilize a variety of evidence-based methods and mainstream therapeutic practices used by mental health professionals worldwide. Importantly, as the proposed Resolution acknowledges, these terms do not distinguish between professionally conducted psychotherapy and religious or other forms of counseling practice, a blurring of categories that carries immense significance for accurately representing change-allowing professional therapies. Unfortunately, SOCE terminology is the current standard vernacular, so we will employ it at times in this comment to signify change-allowing professional talk therapies, though we recognize that licensed therapists in this area of practice find the language of sexual attraction fluidity exploration or therapy-assisted fluidity to be more accurately descriptive of their work.

It should be noted, as well, at the outset that the terms Reparative Therapy® and Reintegrative Therapy® are federally trademarked by the United States Patent and Trademark Office and are entitled to certain federal legal protections. The USPTO description of these two terms falls outside APA's definition of SOCE and so-called "conversion therapy." Deanne M. Ottaviano, General Counsel of the American Psychological Association, was made aware of this last October. Care should be taken not to mischaracterize these specific therapies, for example as to their methods or who engages in them, or make disparaging scientific claims about them without scientific evidence. If the APA conflates Reparative Therapy® or Reintegrative Therapy® with SOCE or conversion therapy, it should expect an instant federal lawsuit for maximum damages. A Resolution statement such as the following is therefore concerning:

> *Sexual orientation change efforts,* or "SOCE," are comprised of a range of harmful techniques practiced by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation or any of its components, often to conform to heterosexual norms (APA, 2009). SOCE have been known by several names, such as "reparative therapy," "reintegration therapy," and "sexual orientation conversion therapy," however the replacement acronym SOCE is preferable, as these methods do not constitute an accepted form of therapy, nor does the term SOCE implicitly suggest that conversion, "repair," or reorientation is likely or necessary for sexual minorities. SOCE may include a variety of modes….

Everything that follows in that paragraph and in the entire document is problematically attributed to Reparative Therapy® and Reintegrative Therapy®.

The Objectivity of the APA Task Force Report on SOCE, Upon Which the Proposed Resolution Builds, is Demonstrably Suspect; Therefore, the Report's Representation of the Relevant

Literature Concerning Efficacy of and Harm from SOCE is neither Complete nor Definitive.

Bias in Task Force Selection

Although many qualified conservative psychologists were nominated to serve on the task force, all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007). It appears that the APA operated with a litmus test when considering task force membership—the only views of homosexuality that were tolerated were those that uniformly endorsed same-sex behavior as a moral good. Thus, from the outset of the task force, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Report's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the task force addressed its work.

Bias Regarding Statements of SOCE Harm and Efficacy

This bias was particularly evident in the task force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Report dismisses most of the relevant research because of methodological limitations, which are outlined in great detail (APA, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the task force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Report appears to adopt very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Report uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that "…it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

The six studies deemed by the task force to be sufficiently methodologically sound to merit the focus of the Report targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of change-allowing talk therapies employs. This brings into question the Report's willingness to move beyond scientific agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Report seems to affirm two incompatible assertions: a) we do not have

credible evidence on which to judge the likelihood of sexual orientation change and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

There are places in the Report that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Report states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly, the Report observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, p. 83; cf. p. 67, 120).

These expressions of agnosticism are justified by the task force but then are not adhered to in the Report's conclusions. Instead, the Report argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Report does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy.

The task force relied on a relatively small number of studies that did not meet its own scientific standards but that reported some people felt harmed by SOCE. Although the task force was unable to use these reports of harm as scientific evidence, it nevertheless still relied on the reports of harm by using them as anecdotal evidence, gave considerable repetitive space to such anecdotal evidence of harm in detail, and based its conclusion on them. The task force also judged that studies showing people changed their sexual orientation and benefitted from SOCE did not meet the task force's exceptionally rigorous standards. The task force could have used these reports that people made significant and meaningful shifts in their sexual orientation and experienced numerous benefits as anecdotal evidence and given considerable repetitive space to them in great detail as well but did not. The Report should have, at minimum, given as much space to the reports from more than a century of research that people changed and benefitted as it gave to the relatively few studies reporting harm. By the end of the Task Force Report, that people said they changed was transformed into people felt better because they talked to someone, and talking to an affirmative therapist who believes they cannot change and rejects their therapy goal can give them someone to talk to with the same effect as talking to someone who is open to their goal of change.

From this highly uneven application of literature review methodology, the Report goes on to assert confidently that the success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the Report, the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14, emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Report.

Bias in Favor of Preferred Conclusions

That the task force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did

in assessing SOCE outcomes can be demonstrated by a few examples. The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions. First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed in the Report and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an even-handed methodological evaluation by the task force would not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There also was an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles.

As Hooker (1993) wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the task force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). Furthermore, the APA has cited Hooker's "rigorous" study in several of its recent amicus briefs (Schumm, 2014). The point here is not to argue for an association between homosexuality and pathology, but to underscore that a consistent application of the methodological standards affirmed in the Report should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

Bias Regarding Treatment of the Primary Study on Harm

Perhaps the most egregious example of the task force's methodological double standard is evidenced in their heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2002) research in conclusions about harm from SOCE. Several methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic therapies: Documenting the damage."
- Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.
- Only 20 participants in this study were women, creating

- significant skew toward gay male accounts.
- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.
- Finally, these subjects reported their experiences came from a mix of licensed therapists, unlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades before. The task force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (Shidlo & Schroeder, 2002, p. 250, emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from change-allowing talk therapies conducted by licensed medical and mental health professionals. Again, what we *can* say with confidence is that some SOCE clients report harm and others report benefit and we do not know from the literature how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for ethical or legal prohibition.

Bias Regarding the Lack of Context Concerning Harm in Psychotherapy

The APA and other professional bodies that utilize this Report are negligent, if not fraudulent, in giving a technically true warning that SOCE may potentially cause harm but failing to do so within the broader context that this warning certainly applies to all forms of psychological care for any and all forms of presenting problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

It should be noted in this regard that there is not a single study which provides prevalence estimates of harm from SOCE using a representative and population-based sample. The APA Report does not make this fact clear and has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame,

2013; Warren, Nelson, Burlingame, & Mondragon, 2012). In addition to psychotherapy deterioration rates, 40-60% of youth drop out of all forms of psychological treatment early (Kazdin, 1996; Nelson, et al. 2013; Wierzbicki & Perkarik, 1993).

These facts have considerable implications for contextualizing the alleged reports of harm and efficacy from SOCE. Deterioration rates significantly beyond 20% would need to be established for professionally conducted SOCE in order for claims of approach-specific harms among youth to be substantiated. Otherwise, the APA is simply targeting one approach to psychological care on ideological and not scientific grounds. Further, the high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved. This could result in a feeling of harm that would be attributable to the premature termination and not SOCE per se.

Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of medical and mental health difficulties *prior* to participating in any SOCE (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; Pakula, Shoveller, Ratner & Carpiano, 2016; Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since change-allowing talk therapies commonly involve helping clients become more aware of the stress and distress in their lives in order to manage or alleviate them, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre-) existing stress and distress. Thus, they may "feel worse" as a consequence of not having allowed therapy sufficient time to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high-quality research that might be able to distinguish such causation simply does not exist.

Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior

It should also be mentioned in the discussions of harm and benefit from SOCE that the Report makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior, and the Resolution specifically recommends suppressing this accurate scientific information with its risks and consequent health disparities.

> BE IT FURTHER RESOLVED that… descriptions that…describe any sexual orientation as…bad for one's health perpetuate stigma for sexual and gender minorities and have deleterious mental health consequences; (Resolution)

An APA Resolution suppressing speech about known harms to health would have deleterious physical health consequences. It would make clear to all that the American Psychological Association is not a reliable source of accurate scientific information

and that it censors accurate scientific information. As a result, whatever the APA might say relevant to sexual orientation or change-allowing therapies and the law would rightly be viewed with skepticism.

Accurate scientific information reveals, for example, that men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the U.S., but make up only an estimated 2-4% of men in the population (Newcomb & Mustanski, 2011). This is occurring in a context where MSM are reporting higher rates of sexual risk behaviors in recent years in spite of increasing cultural acceptance. Similarly, the disparities in emotional distress, suicidal ideation, and suicide attempts between non-heterosexuals and heterosexuals have persisted since the 1990s and even appear to be getting worse for bisexual and lesbian girls (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Porta, Watson, Doull, Eisenberg, Grumdahl, & Saewyc, 2018; Savin-Williams & Ream, 2007). Certainly, whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet efforts to change or otherwise discourage even homosexual behavior among minors, if construed by the client later as SOCE, could jeopardize the license of the therapist under APA promoted legislation.

Bias Regarding Research on the Origins of Same-Sex Attractions

Another example of the task force's uneven application of methodological standards concerns the Report's conclusion that "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation… this research was a significant challenge to the model of homosexuality as pathology" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillem, 1976) revealed many of the same methodological flaws cited in the task force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalizable sample composed of psychiatric patients. All of these problems were considered to be fatal flaws in the task force's appraisal of the SOCE outcome literature for documenting evidence of change.

Given that many of the methodological limitations used by the task force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the task force members chose to definitively accept this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically flawed that one cannot make any conclusive statements

concerning the applicability of developmental factors in the origin of homosexuality. Thus by the task force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

If such ambiguity exists in the SOCE literature on methodological grounds, then by the task force's own criteria, this ambiguity also is present in the referenced etiological research. It appears that the task force has been inconsistent in the application of its methodological critique to the broader literature on homosexuality and it has been willing to offer more definitive conclusions about theories it wishes to dismiss than is warranted by its own standards. In a word, there is again the appearance of substantial bias.

Contrary to the repeated claims of the Report that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exist studies more recent than those the task force cited. They are also high quality and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Baams, 2018; Bearman & Bruckner, 2002; Francis, 2008; Frisch & Hviid, 2006, 2007; Laumann et al, 1994; Roberts, Glymour, & Koenen, 2013; Tjaden, Thoennes & Allison, 1999; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2010). Tjaden et al., reporting on a nationally representative survey, conclude that their finding of a higher incidence of rape before age 18 among women in lesbian cohabitations raises the question: "Do girls who are raped as minors have difficulties relating to males and therefore turn to same-sex relationships?" Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the Report and the Resolution. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

This is underscored by the much higher prevalence rates of childhood sexual abuse (CSA) among non-heterosexuals (Andersen & Blosnich, 2013; Baams, 2018; Corliss, Cochran & Mays, 2002; Friedman et al., 2011; Laumann et al, 1994; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Outlaw et al., 2011; Paul, Catania, Pollack, & Stall, 2001; Tomeo, Templer, Anderson, & Kotler, 2001; Sweet & Welles, 2012; Xu & Zheng, 2015;), and the fact that men experience more distress when sexually assaulted by a man as opposed to a woman (Artime, McCaloum, & Peterson, 2014). Across relevant studies, median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman, Exner, & Baughman, 2011). Furthermore, as Xu and Zheng observe, "It is possible that CSA causes an individual to develop a same-sex sexual attraction" (p. 328). Tomeo and colleagues, who measured sexual orientation before and after experiencing CSA, reported: "Sixty-eight percent of the present homosexual male participants and 38% of the present homosexual female participants … did not identify as homosexual until after the molestation. This suggests that if molestation resulted in homosexuality, this

phenomenon occurs in a greater proportion of male homosexuals." The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors beyond physical, sexual, and emotional abuse (Brown, Masho, Perera, Mezuk, & Cohen, 2015). Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013). These researchers favor the view that attachment insecurity plays a causal role in gender atypicality, though they acknowledge that longitudinal studies are needed to confirm their suspicions. Andersen and Blosnich (2013) reported higher levels of exposure to adverse childhood factors (e.g., mentally ill, substance abusing, or incarcerated family members) for nonheterosexuals that were not likely to be the result of the child's nascent homosexuality, as is sometimes alleged as an explanation for elevated rates of physical and sexual abuse. The authors disagree but acknowledge that, "Some researchers posit that childhood adversity (particularly sexual abuse) may play a causal role in the development of same-sex preferences or sexual minority identity" (p. 5).

One example of this is research suggesting a causal role for childhood sexual abuse in the development of same-sexual orientation is based on a developmental and conditioning paradigm (Beard et al. 2013; Bickham et al. 2007; Hoffman, 2012; O'Keefe et al. 2014). For example, O'Keefe et al. (2014) and Beard et al. (2013) studied the effects of brother-brother incest and sister-brother incest in a sample of 1,178 men. They concluded that, "The origins of this increased interest in sex and the origins of bisexual or same-sex sexual orientations as well as the origins of many of the powerful urges to engage in behaviors such as exhibitionism or to use objects sexually, can be explained as arising from early childhood experiences through the synergistic actions of critical period learning, sexual imprinting, and conditioning" (O'Keefe, et al., 2014, p. 27). These researchers also observed that such processes could account for much of the data that has been utilized to suggest a dominant biological or genetic explanation for non-heterosexuality.

Childhood sexual abuse was studied by the National Health and Social Life Survey (Laumann et al, 1994) that is highly regarded as the most comprehensive study ever conducted on sexuality in America and has not ceased to be cited to this day, inducing in the APA task force Report and the *APA Handbook of Sexuality and Psychology*. It found that men and women who reported being victims of CSA were significantly more likely than participants who did not report CSA to experience other sexual practices or difficulties. These included: not being happy last year, having more than 10 sex partners ever, homosexual/bisexual identification, ever had anal sex with a member of the opposite sex, ever having group sex, being unable to experience orgasm last year, being anxious about sexual performance last year, emotional problems interfered with sex last year. In this study, the definition of CSA included only sexual touch and did not include exhibitionism to the minor. Had exhibitionism been included, it is possible that outcomes might have been more pronounced. CSA was reported to have occurred when 40% of victims were 7 to 10 years of age and 33 % were at or before age 6. The authors noted that women who reported ever in their lifetime being sexually forced showed a remarkably

similar pattern of associated sexual practices and difficulties. It is, of course, possible there was overlap to an unknown degree between women who were victims of childhood sexual abuse and those who were victims of forced sex ever in their lifetime. While these findings do not prove sexual abuse caused homosexuality/bisexuality or associated sexual practices and difficulties, they lend support to the experience of individuals who feel their same-sex sexuality was an unwanted outcome of sexual abuse.

The APA Task Force Report (2009) assertion that same-sex sexuality is not caused by family dynamics or trauma was corrected by the *APA Handbook of Sexuality and Psychology* (2014). The American Psychological Association gave its imprimatur to the *APA Handbook of Sexuality and Psychology (APA Handbook)* and declared it authoritative (Vandenboss, 2014, *1*:xvi). Based on research review, the *APA Handbook* said childhood sexual abuse has "associative and potentially causal links" to having a same-sex partner (*1*:609-610). The *APA Handbook* also said, "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors…. A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful" (Rosario & Schrimshaw, 2014, *1*:583). Psychoanalytic contingencies are generally understood to include psychological causes, family experiences, or parent-child dynamics as developmental causes. Whenever psychoanalytic factors are causal for an aspect of psychological development, there is the likelihood that these factors and their effects are not invariably ideal or normal. It would be astonishing, if not a miracle, if trauma and adverse family dynamics could affect seemingly every aspect of human development except, remarkably, sex—including sexual identity and sexual orientation.

Many who seek change-allowing therapies feel their same-sex attraction or behavior was forced on them by childhood sexual abuse, family trauma, or peer or other trauma and does not represent who they truly are. Is it more compassionate to help them change or to tell them they cannot change and just give them coping methods to go living with it? There are evidence-based treatments for childhood sexual abuse, for emotional ties victims may feel with their abusers, and for trauma and outcomes of family dynamics generally. Affirmative therapists certainly can treat sexual abuse or other trauma. But affirmative therapy assumes *a priori* that same-sex attraction and behavior are never caused by sexual, family, or other trauma, does not evaluate for such potential causes, and does not treat potential links between these experiences and same-sex attraction or behavior. Treatment negligence has the potential to lead to health disparities, that is, ongoing trauma, other life consequences, and suicidality. Worldwide research on suicide found that 90% of people who completed suicide had unresolved mental disorders (Cavanagh et al, 2003). The researchers concluded, "{I}t is our opinion that the core responsibility of doctors in trying to reduce suicide rates remains the identification and treatment of mental disorders" (p. 402).

Bias Regarding Use of the "Grey Literature"

The uneven methodological implementation of standards is again seen in the Report's treatment of the "grey literature," which is dismissed in favor of only peer-reviewed scientific journal

articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly, prospective, longitudinal study on SOCE supportive of change for some individuals and finding no harm on average and significantly improving psychological symptoms is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on page 90 of the Report; see also Jones & Yarhouse, 2011). Yet the task force appears to have no compunction in citing the grey literature on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

Bias in the APA's Broader Treatment of Sexual Orientation

A sixth example of differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the task force applied to the SOCE literature. The Marks study concluded that,

> "…some same-sex parenting researchers seem to have contended for an 'exceptionally clear' verdict of 'no difference' between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, 'the line between science and advocacy appears blurred'" (p. 748).

While Marks' analysis does not focus on change-allowing talk therapies, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in public policy conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the APA task force Report with the banning of professional SOCE.

Recent Research is being used to Advance an Agenda, not the Science of SOCE

Recently, some additional research has reported an elevated risk of harm for SOCE (Bradshaw, Dehlin, Crowell, & Bradshaw, 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Flentje, Heck, & Cochran, 2013; Ryan, Toomy, Diaz, & Russell, 2018). Yet these studies share many of the same methodological limitations of the Shidlo and Schroeder (2002) study.

Flentje et al. (2013). Flentje et al. utilized a small, non-representative sample of 38 participants who self-identified as "ex-ex-gay." The majority of the self-reported, retrospective therapy "episodes" documented were, in fact, provided by religious, pastoral, and peer counselors. Only 34.6% of therapy "episodes" were reported as actually being provided by licensed therapists. There is no way of knowing from this study which provider types engaged in the alleged ethically

dubious interventions. However, the authors did acknowledge that no licensed therapist was ever described by participants as utilizing aversion therapy. Ten participants reported having attempted suicide. Of these, 6 participants reported a suicide attempt prior to their therapy, 7 reported a suicide attempt during SOCE, and one indicated suicide attempts following the conclusion of their treatment. These findings suggest a significant portion of the sample was experiencing serious emotional distress *prior to* their SOCE, and the occurrence or degree of emotional harm due to their therapy experience simply cannot be ascertained in the absence of longitudinal data.

Reported costs of SOCE appear to be highly skewed by the presence of one or more outliers. For example, the mean costs of all SOCE per participant were $7105 and the median cost $2150, with a standard deviation of $11384. These costs were reported to range between $0 and $52000, again indicating at least one severe outlier. It is curious that when the authors attempt to make the case against SOCE in the discussion section, they choose to cite the inflated mean figure for total costs rather than the more appropriate (and less dramatic) median statistic.

Dehlin et al. (2015). Dehlin et al. tend to tout their study as providing a large and diverse sample of Mormon SOCE participants. Although the study sample is relatively large, it lacked diversity in that only 29% of participants were still actively engaged with the LDS church. Thus, the sample consisted overwhelmingly of participants who were moderately to highly disaffected from their church, which raises concerns about the representativeness of the sample and the response bias this disaffection may have introduced against SOCE specifically and conservative values in general.

Participants were asked to rate their SOCE experiences on a 5-point scale, from 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, and 5 = *severely harmful*. This is a highly unusual rating scale in that it is anchored by terms that are actually measuring different dimensions, i.e., effectiveness and harm. To be consistent with most research, Dehlin and colleagues should have provided participants with two scales, one anchored by *highly effective* on one end and *highly ineffective* on the other end and the other by *significantly beneficial* and *significantly harmful*.

Note also that the midpoint of the scale is *not effective*, which is far from the typical neutral rating one would expect to find at the center point of a scale. This also is hard to fathom and clearly promotes a biasing effect toward SOCE as lacking effectiveness. Put another and simpler way, the scale offered participants two positive options and three negative options. Is this biased? If it had instead offered three positive options and two negative options, the results might have been quite different. As it stands, the conflation of harm and effectiveness in the response scale used in this study creates significant uncertainties about what the results actually mean. Certainly, outcomes would have been more favorable had Dehlin et al. defined the midpoint as *not harmful* rather than *not effective*, which would have been an equally arbitrary methodological decision.

In spite of these problems with scale definitions and their potential biasing toward ineffective SOCE ratings, therapist-led SOCE methods actually did receive mildly positive endorsements. Psychotherapy was found to have moderate or greater *effectiveness* by 44% or respondents who sought it, with respective effectiveness ratings of 48% for psychiatry and 41% for group therapy.

Finally, as with Flentje et al., the study combined religious and professional SOCE providers in deriving its findings, and the vast majority of SOCE did not involve licensed therapists. It should be noted that while Bradshaw et al. (2015) analyzed a subsample of the Dehlin et al. database who reported engaging in professional psychotherapy, this study suffers from the same sample and measurement concerns.

Ryan et al. (2018). This study is important in that it focuses on minors and concludes with the implication their research supports legislative and professional regulatory efforts to prohibit licensed therapists from engaging any minor in change-allowing talk therapies. This is a highly questionable conclusion for several reasons. Ryan, Toomey et al. did not disentangle participants' retrospective perceptions of the effects of licensed therapists from that of untrained religious leaders, so it is impossible to rule out the common-sense suspicion that negative effects were an outcome far more attributable to the practices of the latter group, as the Dehlin et al. (2015) data suggest. Participants were asked if they were involved in attempt to "cure, treat, or change" their sexual orientation. The concept of "cure, treat, or change" is also quite nebulous. This language may not only have served as a prompt for more negative responding, but presumably was elastic enough in participants' minds to include anything from simple prayers for healing ubiquitous in conservative religious circles to snapping a rubber band around the wrist or other aversive methods for which no ethical and trained contemporary professional therapist advocates.

The study explicitly excluded individuals who as adolescents initiated change-allowing therapies for themselves. Only parent-initiated therapy was considered and only among individuals who later as young adults identified as LGBT.

By limiting their sample to LGBT identified young adults recruited through LGBT venues who self-identified in adolescence and who did not report experiencing any sexual orientation fluidity, Ryan et al.'s sample excludes by definition those sexual minorities who may have felt some benefit from religious and professional experiences that could be viewed as non-affirming. Adolescents who experienced a meaningful shift or change in same-sex attraction or behavior through therapy do not as young adults self-identify as LGBT and go to LGBT bars, clubs, or service agencies where they could be recruited for research. Thus, the nature of the sample may overestimate harm. There is also growing evidence that constructs and conclusions derived from LGBT-identified samples may not be easily transferrable to non-LGBT identified sexual minorities with primary religious identities (Hallman, Yarhouse, & Suarez, 2018; Lefevor, Sorrell, Kappers, Plunk, Schow & Rosik, 2019).

General Critique of Recent SOCE Research. Licensed therapists on all sides of the debate over SOCE are agreed in the commitment to do no harm to their clients. The question is whether the harms attributed to change-allowing talk therapies are unambiguously grounded in scientific data sufficient to justify ethical or legal bans or whether what we are witnessing is the triumph of advocacy interests over sober science. As noted above, the more recent SOCE research all contain serious methodological limitations, including sample bias favoring negative SOCE accounts, measures defined in a manner that inflates estimates of harm, and the confounding of professional and religious SOCE providers and interventions. The findings of this body of research cannot

therefore be generalized beyond the samples employed and provide an insufficient scientific basis for justifying therapy bans.

However, the fatal flaw these studies all evidence is their inability to control for pre-SOCE levels of distress, which is a key component for disentangling distress attributable to a psychotherapeutic intervention and distress experienced by clients prior to ever engaging in therapy. Without this data, the actual degree of harm attributable to therapy is unknowable. This is a critical fact of basic research methodology, particularly when the population under study is known to have high levels of adverse childhood experiences. To cite only one example, non-heterosexual persons report much higher levels of childhood sexual abuse (CSA) than heterosexual persons, as was addressed above (Baams, 2018; Friedman et al., 2011; Laumann et al, 1994; Rothman et al., 2011: Xu & Zheng, 2015;), and CSA has been linked to later suicidality (Bebbington, et al., 2009; Bedi et al., 2011; Eskin, Kaynak-Demir, & Demir, 2005. Hence, without pre-SOCE assessment of participants' suicidality, claims attributing frequent suicidal thoughts and behaviors to be the direct result of change-allowing talk therapies constitute empirically unfounded speculation.

It is also worth evaluating these more recent studies using the same methodological standards the APA (2009) Task Force utilized to discard most of the SOCE literature. As summarized by Beckstead (2012):

> Methodological errors in SOCE research included the following: (1) results are based on restricted, self-selected samples that represented a socially stigmatized population who affirmed heterocentric biases; (2) methods did not account for participants' interests to manage self-impressions and potential to promote their beliefs and lifestyles and misreport ''successes'' and ''failures''; (3) some results were based on therapists' subjective impressions; (4) researcher biases or lack of expertise were not managed or addressed; (5) comparison or control groups were not used; and (6) longitudinal methods were not utilized to determine the duration or process of any positive changes. (p. 124)

With the possible exception of #3, all of these "errors" the Task Force found in the research purporting SOCE effectiveness could equally be applied to the recent research alleging SOCE harms. This double standard in scientific evaluation was noted at the time of the Report (Jones et al., 2010) and apparently continues into the present, suggesting the enduring influence of advocacy interests over scientific humility.

To summarize, a proper conclusion regarding the recent research is that these studies cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and therapists to provide change-allowing professional psychotherapy. In fact, due to the sampling problems, utilizing this research to evaluate the provision of change-allowing talk therapies makes no more sense than studying a sample of former marital therapy patients who have subsequently divorced to determine the effectiveness and harm of marital therapy in general.

Non-heterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People and Particularly among Females and Youth.

Central to the notion that some individuals can and do report change on a continuum of change in their sexual orientation is the issue of *immutability*. The APA Task Force Report said one of the "key findings in the research" on which it "built" its conclusion was that sexual orientation does not change through life events (2009, pp. 63, 86). Were all same-sex attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise among minors or adults.

Already in 1994, however, the National Health and Social Life Survey (Laumann et al) discovered "assumptions that are patently false: that homosexuality is…stable over time…" (p. 283). Well before the APA task force convened its work, one of the "key findings in the research" on which it "built" its conclusion, that sexual orientation does not change through life events, had been shown to be "false."

There is ample additional solid data to suggest that same-sex attractions and behaviors are not fixed but are subject to varying degrees of change. As summarized by Ott et al., (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). Hu, Xu, and Tornello (2016) studied longitudinal data and observed, "In the LGB [lesbian, gay, and bisexual] population, the dominant pattern was change." Dickson, van Roode, Cameron, and Paul (2013) further asserted that "People with changing sexual attractions may be reassured to know that these are common rather than atypical (p. 762). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "…the importance of viewing sexual orientation as a process which often changes over time" and noted "…the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

Lack of Agreement Regarding what Constitutes Sexual Orientation

Contrary to conventional wisdom, there is substantial debate within scientific circles as to what constitutes sexual orientation, and this uncertainty extends to terms such as "sexual orientation change efforts." Sexual orientation may be said to comprise same-sex attractions, fantasies, and behaviors, but this is insufficient to guide change-allowing talk therapists in knowing clearly whether what they are discussing with a client could be considered as a *sexual orientation* change effort. That term is nebulous, and many scholars admit they have no precise means of distinguishing sexual orientation from same-sex sexuality, *i.e.*, same-sex behaviors and attractions that may not signify a same-sex orientation (Diamond, 2003). Relatedly, Savin-Williams (2016) described sexual orientation as being a continuum rather than discreet categories, which theoretically could mean that an isolated same-sex attraction in an otherwise completely heterosexual person might be considered as a separate sexual orientation or truly novel change (See also Diamond, 2014, *APA Handbook, 1*:632). Echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue

for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125). Finally, Diamond and Rosky (2016) acknowledged these problems when they indicated,

> ….it is important to note that sexual orientation is not easy to define or measure. This obviously poses a problem for research on the causes of sexual orientation, given that the first step in such research is to identify individuals with different sexual orientations. (p. 365).

One could rationally argue that this also poses a problem for the politics of SOCE ethics statements or ban legislation.

Non-Heterosexuality Not a Fixed Trait

The definitive study by Laumann, Gagnon et al. (1994), cited by the APA (2009) task force and several times in the *APA Handbook of Sexuality and Psychology* (2014), involved several thousand American adults between the ages of 18 and 59. This report contains the most careful and extensive database ever obtained on the childhood experiences of matched homosexual and heterosexual populations. One of the major findings of the Laumann et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely seemed to exist (p. 283f). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report:

> …this implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42 percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296) percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296

They also note that their findings comport well with other large-scale studies.

> [O]verall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys…one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

These data seem to suggest that heterosexuality is normative, even for those who at one point in the past reported a non-heterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among non-heterosexual individuals" (p. 104). Mock & Eibach (2012) found that heterosexuality

was more stable than homosexuality or bisexuality over a 10-year period in middle-aged adults. Nearly half of women with initial bi- or homosexual identity opted for a different label 10 years later. Diamond and Rosky summarize the matter well: "Given the consistency of these findings, it is no longer scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait" (p. 370).

Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e., heterosexual. Therefore, it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

Whether measured by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life occurred largely in one direction--toward heterosexuality—and reflected a significant decline in non-heterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly a picture of sexual orientation stasis in adolescence that the APA Task Force Report (2009) and some legal therapy bans seem to assume. To be fair, we cannot tell from this data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that change-allowing talk therapies could aid some individuals (minors or adults) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a non-heterosexual sexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies disallowing the potential for change (e.g., "gay-affirmative") could be interfering with normal sexual development.

Fluidity of Non-Heterosexual Sexual Attractions and Identity is Commonplace

Diamond's longitudinal studies of women with non-heterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted, "Hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (italics in original, p. 13). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "…demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to (Diamond, 2008, p. 12).

Farr, Diamond, and Boker (2014) presented evidence for the existence of subtypes of non-heterosexual women, both in the intensity or degree of their same-sex attractions and in how these attractions change over time. She noted that these women appear more likely than men to specifically report the roles of *circumstance, chance, and choice* in their sexual identity and orientation, concluding that, "These results support the notion that some degree of plasticity may be a fundamental component of female same-

sex sexuality" (p. 1487). Dickson et al. (2013) reviewed the relevant scientific literature and concluded, "These studies demonstrate that there is more change in sexual orientation than would be expected from repeated cross-sectional studies and change appears to be more common among women than men" (p. 754).

Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted change-allowing talk therapies as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided adequate assessment to ensure voluntary and informed consent. Finally, echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

Although the general scholarly consensus is that non-heterosexual women are more fluid in their sexual attractions and behaviors than are men, this may not be the case. As Diamond (2017) noted, "Female sexuality was once thought to be more fluid and plastic than men's, but recent research has begun to challenge this view" (p. 1184). This includes research on sexual orientation fluidity by Katz-Wise (2015) and Katz-Wise & Hyde (2015). These researchers studied a sample of young adults (18-26 years of age) who reported a same-sex sexual orientation. They discovered that 63% of the women and 50% of the men reported fluidity in their sexual attractions, and of these individuals 48% of the women and 34% of the men also reported change in their sexual orientation identity. Of additional import for evaluating the legitimacy of ethical or legal bans, participants who reported fluidity indicated that their initial experience of change in sexual attractions occurred on average *before* the age of 18.

More recently, Diamond (2016) reviewed relevant studies and concluded,

> The other major conclusion that we can draw from these studies is that change in patterns of same-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented…between 25% and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon. (p. 253)

The *APA Handbook of Sexuality and Psychology* (2014), with the imprimatur of the APA, attests that same-sex attraction, behavior, and identity—all three—change for both adolescents and adults. It says, "...research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time." (Diamond, L., 2014, Chapter 20: Gender and same-sex sexuality, in *APA Handbook*, *1*: 636.) "Although change in

adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation." (Rosario, M. & Schrimshaw, E., 2014, Chapter 18: Theories and etiologies of sexual orientation, in *APA Handbook*, *1*: 562.). "Over the course of life, individuals experience the following: (a) changes or fluctuations in sexual attractions, behaviors, and romantic partnerships;…" (Mustanski, B., Kuper, L., and Geene, G. (2014), Chapter 19: Development of sexual orientation and identity, in *APA Handbook*, v. 1, p. 619.)

Diamond and Rosky frankly admit that "born that way and can't change" has long been fake science and political advocacy (2016, p. 10).

> Since that time, *the Academy of Science of South Africa has published its own comprehensive report summarizing the biological evidence* regarding sexual orientation and arguing against the criminalization of same-sex sexuality (Academy of Science of South Africa, 2015). *The authors deployed the same exaggerations of scientific evidence that have long characterized immutability debates,* concluding that "all sexual orientations are biologically based, largely innate and mostly unchangeable" (p. 22, emphasis added).
>
> In African nations, these debates have dire implications: Same-sex conduct is illegal in 37 African nations and punishable by death in seven. When immutability claims are the only way to save lives, it makes both *strategic* and moral sense for *scientists and advocates to highlight* scientific findings that support these claims. Yet in the United States, the social and legal context is obviously more favorable to sexual-minority rights, and *immutability claims are no longer necessary, nor particularly effective*. (p. 10, emphasis added)

The authors do not oppose professional organization reports based on exaggerated science and political advocacy in Africa, an approach that is insulting to the average African, appearing to assume Africans are so backward that they would not know how to access computers or other sources of information to realize their professional organization is lying to them. Here is a clear example for Africans—and for all—that professional organizations are not necessarily reliable sources of accurate scientific information on political issues. Diamond and Rosky approve of professional organizations lying. They just do not think the falsehood of immutability is needed or effective in America anymore. Certainly, saving lives is a vital matter, but an approach that respects the intelligence of Africans and speaks to the conservative values of these cultures may be better assimilated and leave less upheaval in its wake. Meanwhile, one is left to wonder whether these authors believe "can't change through therapy" is exaggerated science, and professional organizations' resolutions on therapy are fake science and political advocacy that is still needed in America. As they are giving up immutability, they are yet hanging onto immutability in therapy.

Driving the final nail into the coffin on born that way, can't change, and can't choose, Diamond & Rosky say, "[A]dvocates for sexual minorities have…[argued] that sexual orientation is a fixed, biologically based trait that cannot be chosen or changed" (p. 2) and "openly scolded" individuals who said they experienced otherwise (p. 20). [A]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course" (p. 2). "We hope that our review of scientific findings and legal rulings regarding immutability will deal these arguments a final and fatal blow" (p. 3).

In light of the reality of change, it is noteworthy that the Katz-Wise studies reported sexually fluid participants and women were more likely than sexually non-fluid participants and men to believe that sexual orientation is changeable. Non-sexually fluid men were more likely than sexually fluid men to believe that sexuality is something an individual is born with, while men who reported experiencing sexual fluidity were more likely than men who did not report sexual fluidity to view sexuality as changeable and subject to environmental influences. These findings may help explain the overwhelming dominance of men who provide testimony and personal anecdotes in favor SOCE legal bans, suggesting that non-heterosexual men who have not experienced change may assume that this is the case for all non-heterosexuals and support professional organization resolutions and laws that ban professional change-allowing talk therapies for even sexually fluid male youths who freely seek assistance with their pursuit of change.

Diamond (2008, 2016) and the Resolution emphasize that fluidity is not willful shifts but change that unfolds over time. Change-allowing therapists also do not think of change as something that is simply willed. If they did, they would see no need to offer therapy to assist client's desiring change. But Diamond reported some women did make willed choices that in turn affected the direction of their fluidity (2008), such as going into a male dominated career that increased opportunities to have relationships with men versus staying predominantly in a lesbian community, or choosing to marry a man because the woman wanted to conceive and raise children with her partner. Diamond said one may *choose* a context or circumstance that may influence sexual orientation change, including sexual attraction change, such as choice of roommate (2008, pp. 249-250), deciding to live in an ideological, political, or social reference group—as in "political lesbians" (2014, in *APA Handbook*, v.1, p. 632), or being in therapy that is open to change (2008, p. 252). The women in her longitudinal study did not have this knowledge and could not have used it to make a conscious choice of context or circumstance if they had the motivation to do so. But there is no reason why someone who wanted to try to influence the direction of fluidity could not do so and no reason why a therapist could not educate a client about factors known to affect fluidity for some.

Change Among Transgendered/ Transsexual Individuals

Intriguing research among transgendered persons finds that these individuals often report a change in their sexual orientation (Auer, Fuss, Hohne, Stalla, & Sievers, 2014). These researchers found almost 21% of their sample of 115 transsexual participants reported experiencing a

change in their sexual orientation. They noted that, "Transition [surgically from the appearance of one sex to the other] was not directly involved in this change, since a significant number of participants reported a change in sexual orientation prior to first psychological counseling and prior to initiation of cross-sex hormone treatment. The participants provided diverse individual explanation models, revealing that personal history, social environment as well as autoerotic feelings may impact on a change in sexual orientation" (p. 11). They observed that these changes may even be affected by personal decision, quoting one participant as stating, "While some people think that gender identity is something you acquire or learn, I think this was rather true for my alleged sexual orientation" (p. 9). While this study may raise more questions than it ultimately answers, it further undercuts an understanding of sexual orientation as a stable self-construct that is unchangeable for all persons in all circumstances. Moreover, it is worth asking whether a licensed therapist assisting a transgendered adolescent would be legally liable under an ethical or legal ban should that adolescent report an undesired change of sexual orientation in the process of transitioning.

Change Not Limited to Sexual Behavior

A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to taken place in the years prior to 21 in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role of the social environment in the development and expression of sexual orientation.

More recently, similar findings were reported among a sample of 116 polyamorous and monogamous individuals (Manley, Diamond, & van Anders, 2015). The authors suggest "the prevalence of attractions shifts contradicts notions of attraction as stable and partnering behaviors and sexual identities as more fluid. Attraction shifts were far more common than shifts in either sexual identity or partner gender" (p. 177).

Change Particularly Evident for Bisexuals

Mental health professionals who are open to exploring sexual fluidity through therapy agree with the authors of the Resolution that most sexual minorities experience both-sex sexuality, contrary to the Resolution's mischaracterizing assertion of change-allowing therapists.

> WHEREAS, the majority of sexual minorities are bisexual rather than exclusively lesbian or gay and SOCE protocols tend to oversimplify, misrepresent, or dismiss bisexuality.

According to the American Psychological Association's *APA Handbook of Sexuality and Psychology* (2014) and abundant rigorous research internationally, most people who experience same-sex attraction also experience equal or greater opposite-sex attraction. Like many people, some both-sex attracted people desire both to conceive and to raise children with their spouse. Many both-sex attracted people are in opposite-sex relationships by preference, and many who seek SOCE want to save their marriage and family. Some same-sex attracted adolescents aspire to have an opposite sex marriage and family.

The *APA Handbook of Sexuality and Psychology* says,

> Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception. (Diamond, 2014, *1*:633)

This pattern has been found internationally (Diamond, 2014, *1*:633; Diamond & Rosky, 2016).

A large, rigorous, nationally representative study (Savin-Williams et al, 2012) that followed young adults beginning when they were ages 18 to 24 and following up when they were about 24 to 36 found the following: "The largest identity group, second only to heterosexual, was 'mostly heterosexual' for each sex and across both age groups, and that group was 'larger than all the other non-heterosexual identities combined'" (abstract). "The bisexual category was the most unstable" with three quarters changing that status *in 6 years* (abstract). "[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality" (p 106).

Mostly heterosexual individuals generally do not identify as LGBT and are therefore automatically omitted from the research of only non-heterosexuals who identify as LGBT (examples: Ryan et al, 2009; Ryan et al, 2010; Ryan et al, 2018).

Emphasizing the capacity for both-sex sexuality to change is not to say that exclusively same-sex sexuality does not change through life events. In this study, about 1 in 4 lesbians (24%) and about 1 in 12 to 13 exclusively homosexual men (9%) changed along the spectrum toward heterosexuality during the 6-year period of this study.

As we have outlined, both-sex attracted individuals have a large capacity for sexual orientation change. They commonly shift along a spectrum that ranges exclusively from exclusively homosexual to mostly homosexual to bisexual (about equally attracted to both sexes) to mostly heterosexual to exclusively heterosexual. They change along this continuum mostly toward or to exclusively heterosexual. A shift of 1 step along that spectrum is considered by

researchers to be sexual orientation change, and not only change that goes from one end of the spectrum to the other end. A change of even 1 or 2 steps toward or to exclusive heterosexuality may enable some to live their dream. Should they have the right to counseling they may need and desire to explore their capacity to make that change?

Changes are more pronounced among, but certainly are not limited to, bisexuals and women. But keep in mind that ethical or legal bans do not discriminate in their prohibition between SOCE provided for exclusively same-sex attracted minors or adults and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor do ethical or legal bans distinguish between boys and girls, men and women. The reality of such spontaneous changes in sexual orientation is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to change-allowing talk therapies and only allow affirmation of same-sex feelings in adolescence or adulthood on the grounds that the feelings are intrinsic and unchangeable, and therefore the individual can only be homosexual or can never change.

A blanket prohibition on SOCE for all minors or adults with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw in its inability to address the complex realities of sexual orientation. For example, a study by Herek et al. (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian woman reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in change-allowing talk therapies for some individuals. Even more important, however, are Herek's findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. These numbers create a significantly different impression about the enduring nature of sexual orientation and the role of willed choices in the process of change than the picture often painted by proponents of legal bans. At a minimum, such data suggest that proponents of ethical or legal bans would do better to exclude bisexuality from the scope of bans. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that change-allowing talk therapies might augment this process for some individuals with unwanted same-sex attractions and behaviors?

Identification of the Mostly Heterosexual Orientation

Further evidence that ethical or legal bans ignore distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2-3% of men and 10-16% of women over time and constitutes a sexual orientation larger than all other non-heterosexual identities combined (Savin-Williams, Joyner, & Rieger, 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other non-heterosexual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent

physiological evidence in a sample of men (Savin-Williams, Rieger, & Rosenthal, 2013). This apparently viable and unique group of non-heterosexuals raises serious questions for the scope of ethical or legal bans; namely, are "mostly heterosexual" minors or adults exempt from a ban on SOCE? The fact that proposed ethical or legal bans appear to be oblivious to such important nuances highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding change-allowing talk therapies at the behest of activists within and outside professional organizations.

All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth) and that this change is best conceptualized as occurring on a continuum and not as an all-or-nothing experience. The experience of clinicians who engage in change-allowing talk therapies is that while some clients report complete change, and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity. Descriptions of licensed therapists engaged in SOCE as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (see Alliance for Therapeutic Choice and Scientific Integrity (ATSCI), 2018). Licensed therapists who provide change-allowing care recognize that change of sexual orientation typically occurs on a continuum of change, and this is consistent with how change is understood to occur for most, if not all, other psychological and behavioral conditions addressed in psychotherapy.

Genetics and Biology are at Best Partial Explanations for Same-Sex Attractions

Moreover, such fluidity and change makes clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth and there is no convincing evidence that biology is determinative for many if not most individuals (Diamond & Rosky, 2016). The American Psychiatric Association has observed that, "…to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau et al. (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation…Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation."

The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large-scale studies of identical twins. Identical twins share genes, environmental conditions in the womb, and number of older brothers. These studies indicate that if one twin sibling has a non-heterosexual orientation the other sibling shares this orientation only about 11% of the time with upper estimates at 24% (Bailey, Dunne, & Martin, 2000; Bailey, Vasey, Diamond, et al, 2016; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Xu, Norton, & Rahman, 2019). If factors in common like genetics, conditions in the womb, and number of older brothers overwhelmingly caused same-sex attractions, then identical twins would *alway s* be identical for same-

sex attraction. These studies instead suggest that the largest influence in the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses. Xu and colleagues (2019) concluded, "Thus, most of the differences between people in their sexual orientation are due to environmental factors (often nonshared) pointing to multiple etiology" (p. 1).

Some have argued that gender-nonconforming behavior that is often observed to precede same-sex sexuality is biologically determined. But if one twin is gender nonconforming, the other usually is not, indicating that gender nonconformity also is largely determined by environmental factors after birth (Bailey, Vasey, Diamond, et al, 2016, 76).

Similarly, heritability of sexual orientation is approximately .32, indicating that 32% of the population variability in sexual orientation is due to genetic factors (Diamond & Rosky, 2016; Bailey, Vasey, Diamond, et al, 2016). Heritability is the variability between persons in a population, not indicative of the relative contributions of genetic and environmental influences within individuals. Diamond and Rosky put this in perspective by stating, "…it is helpful to note that higher estimations of heritability (ranging from .4 to .6) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction (p.366)." Given these statistics, it is curious that, for example, smoking is a behavior considered subject to change, while proponents of SOCE bans often maintain sexual orientation is an immutable behavioral characteristic.

One may note that all of these phenomena that have higher heritability rates than same-sex attraction—being divorced, smoking, having lower back pain, and feeling body dissatisfaction—are considered changeable through therapeutic intervention. (For example, the American Psychological Association offers a smoking cessation app, the APA SmokeScreen Mobile App.)

Interestingly, other traits that have heritability rates comparable to that for sexual orientation (.32) are religion and spirituality (.31) and individual attitudes (.35). None of these is considered an innately determined trait (Polderman et al, 2015; Bailey et al, 2016). In fact, an article in *Monitor on Psychology* that presents for continuing education credit the model of affirmative therapy for individuals who experience conflict between their same-sex sexual thoughts and their faith (Novotney 2017) suggests therapists propose to clients the option of changing their faith to match their same-sex thoughts. Since the genetic contribution to both is virtually the same, it would seem the reverse option should also be offered, namely clients changing their sexual thoughts to match their faith.

Causatively, then, sexual orientation is by no means comparable to a characteristic, such as skin color or biological sex, that is thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices such as those which might be facilitated in change-allowing therapies. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of portraying same-sex attractions and behaviors as static traits only to be embraced by minors or adults who might

otherwise desire the option of exploring change.

Sexual Fluidity and Change-Allowing Talk Therapies

Although no reputable scholar can now deny that the components of sexual orientation evidence significant fluidity for many non-heterosexual persons, the adamant contention of SOCE ban supporters is that such naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-allowing talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-allowing talk therapies often address these exact influences with their clients. For example, same-sex attraction fluidity is known to sometimes occur in response to changes in emotional and romantic attachments. Hu et al. (2016) reported, "The results suggested that people who report same-sex attractions with no relationship or an opposite sex partner were more likely to shift their same-sex attractions than those who reported a same-sex relationship" (p. 658; see also Diamond, 2008). In evaluating neurobiological research, Diamond and Rosky (2016) noted that "…one possibility [for shifts in sexual attractions] is that the formation of emotional attachments may facilitate unexpected changes in sexual desire" (p. 370). Similarly, Manley et al. (2015) assert, "…research on sexual fluidity suggests that, for some people, relationships may in fact influence sexual orientation, meaning that emotionally intimate relationships may lead to sexual attractions toward a gender to which one had not previously been attracted" (p. 168). Change-allowing talk therapies may address exactly such influences, assisting clients with their relationships in ways that for some may facilitate genuine shifting in sexual attractions and behaviors.

At this point in time, there are only political as opposed to theoretical obstacles to acknowledging some people can be their own agents of change in a process assisted by change-allowing talk therapies, including minors. Therapists who engage in this work report such experiences with some regularity, though certainly not for all clients. Research in this arena is of course very desirable, but hard to come by, for many reasons. Demands for such research seem to ignore the fact that (1) it is quite difficult to study a therapy process that is being made illegal, (2) funding sources for such research typically have vested interests in the outcomes as do the researchers, (3) obtaining findings favorable in any way to change-allowing talk therapies will likely result in marginalization and professional ostracizing of the researcher, bullying from the press, and voluminous hate mail against the researcher that few are able to bear accompanied by relentless pressure to get the publication expunged (Wood, 2013; van den Aadweg, May 31, 2012; Nicolosi, January 11, 2016).

As a case in point, all these forms of punishment fell upon Robert Spitzer (van den Aadweg, May 31, 2012; Nicolosi, January 11, 2016)) who conducted one of the primary studies on SOCE (2003), furnishing evidence that some people can shift or change their sexual attraction through change-allowing therapies. Spitzer had thought liberals would understand and appreciate helping any marginalized group, including sexual minorities who desire change. He was shocked by the bullying from the press and the voluminous hate

mail from gays he received. Finally, in his 80's, old and frail, dying of Parkinson's disease, and under pressure from an activist journalist, Spitzer questioned his original assessment of his study.

Spitzer came to believe that his study (2003) did not provide clear evidence of sexual orientation change (Spitzer, 2012). It appears that he then initially may have wished to retract his study, but the editor of the journal in which the study was published, Kenneth Zucker, Ph.D., denied this request. Zucker has been quoted regarding his exchange with Spitzer as observing:

> You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified—or the journal retracts it if the editor knows of it. As I understand it, he's [Spitzer] just saying ten years later that he wants to retract his interpretation of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to interpretation, and we don't do that. (Dreger, 2012)

What Zucker is essentially saying is that there is nothing in the science of the study that warrants retraction, so all that is left for one to change is his interpretation of the findings, which is what Spitzer appears to have done. Spitzer's change of interpretation hinged on his new belief that reports of change in his research were not credible, an assertion made by others at the time the study was published and that he had already anticipated and addressed in the study itself. After years of standing by his study, he changed to a view that participant's accounts of change may have involved "self-deception or outright lying" (Spitzer, 2012).

It is curious that Spitzer's (2012) apology seems to imply that he earlier claimed his research proved the efficacy of SOCE. As was understood at the time, the design of Spizter's study ensured his research would not definitively *prove* that change-allowing talk therapies can be effective. Certainly, it did not prove that all gays and lesbians can change their sexual orientation or that sexual orientation is simply a choice. The fact that some people inappropriately drew such conclusions appears to be a factor in Spitzer's reassessment. Yet the fundamental interpretive question did and still does boil down to one of plausibility: Given the study limitations, is it *plausible* that some participants in SOCE reported actual change?

Since nothing has changed regarding the scientific merit of Spitzer's study, the interpretive choice one faces regarding the limitations of self-report in this study also remains. Either all of the accounts across all of the measures of change across participant and spousal reports are self-deceptions and/or deliberate fabrications, or they suggest it is possible that some individuals actually do experience change in the dimensions of sexual orientation. Good people can disagree about which of these interpretive conclusions they favor, but assuredly it is not unscientific or unreasonable to continue to believe the study supports the plausibility of change.

In fact, the reasonableness of this position was bolstered by the willingness of some of the participants in Spitzer's research to speak up in defense of their experience of change (Armelli, Moose, Paulk, & Phelan, 2013). They expressed clear disappointment in Spitzer's new claims:

> Once thankful to Spitzer for articulating our experience and those of others, we are now blindsided by his "reassessment," without even conducting empirical longitudinal follow-up. We know of other past participants who also feel disappointed that they have been summarily dismissed. Many are afraid to speak up due to the current political climate and potential costs to their careers and families should they do so. (p. 1336)

It seems clear, then, that unless one postulates initial and ongoing self-deception and fabrication by participants to an incredulous degree, Spitzer's study still has something to contribute regarding the possibility of change in sexual orientation.

It appears there will need to be a change, or at least a significant shift, in the ideologically unbalanced professional culture of psychology before we can undo the current politically required foreclosure on the science of talk therapy-assisted fluidity in same-sex attractions and behaviors. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148).

Stigma, Discrimination, and SOCE

Proponents of change-allowing talk therapy bans typically frame a significant degree of their arguments concerning harm and SOCE on the negative consequences of stigma and discrimination. While these factors certainly can have deleterious consequences for those with non-heterosexual sexual orientations, this possibility must be placed within a broader context and balanced by additional considerations.

The Limited Understanding of the Dynamics of Stigma and Discrimination

From an overall perspective, the meta-analytic research (which summarizes results over multiple studies) on the association between perceived discrimination and health outcomes indicates that the strength of this relationship is significant but small (Pascoe & Richman, 2009). Schmitt, Branscombe, Postmes, and Garcia's (2014) updated meta-analysis found LGB-related discrimination (i.e., heterosexism) explained less than 9% of the relationship between discrimination and well-being and between discrimination and psychological distress. Furthermore, research into what influences this association has most typically found no significant role for theoretically linked factors such as various coping strategies, social support, concealing one's LGB identity, and identification with one's group (i.e., claiming a gay identity) (Denton, Rostosky, & Danner, 2014; Schmitt et al., 2014). For example, data suggest that the impact of "internalized homophobia" for understanding risk behavior among men who have sex with men (MSM) is now negligible and, "The current utility of this construct for understanding sexual risk taking of MSM is called into question" (Newcomb & Mustanski, 2011, p. 189). By contrast, poly drug use by these men continued to be a strong predictor of risky sexual behavior. Similarly, a meta-analysis of studies examining the higher substance

use rates among LGB youth compared to their heterosexual peers concluded that internalized homophobia was not a significant predictor (Goldbach, Tanner-Smith, Bagwell, and Dunlap, 2014). Such findings should be sufficient to indicate that there is a great deal left to be understood about this entire field of study.

Other lines of inquiry suggest that sexual orientation stigma and discrimination alone are far from a complete explanation for greater psychiatric and health risks among non-heterosexual orientations. Goldbach et al. (2014) discovered that the factors having the greatest relationship to substance use in LGB youth were not distinct from those reported by teens in the general population, regardless of sexual minority status. Victimization that was not specifically gay-related had the strongest association with substance use for these youth. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. The associations between non-heterosexual orientation and poorer mental health have persisted over time with recent studies showing the same effects as older studies (Branstrom & Pachankis, 2018; Sandfort, de Graaf, ten Have, Ransome, & Schnabel, 2014; Semlyen, King, Varney, & Hagger-Johnson, 2016).

The issue of suicide among non-heterosexual persons is worthy of great concern. Yet contrary to a singular reliance on minority stress theory to explain sexual orientation disparities, research is discovering that suicide related ideation and behavior disparities are not uniformly decreasing with the greater social acceptance of LGB people, both among minors and adults (Peter et al., 2017; Wang, Ploderl, Hausermann, & Weiss, 2015). Men with same-sex attractions and behaviors were found to have a higher risk for suicidal ideation and acute mental and physical health symptoms than heterosexual men in Holland, despite that country's highly tolerant attitude towards homosexuality (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; de Graaf, Sandfort, & ten Have, 2006). Even in a highly tolerant country such as Sweden, same-sex married individuals evidenced a higher risk for suicide than other married persons (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016). Wang et al. chastised researchers studying suicidality among non-heterosexual persons for their failure to consider other common factors in the general suicide literature: "It is notable, however, that certain areas of mainstream suicide research—e.g., consideration of biologic factors, psychological factors (e.g., personality traits), and stressful life events—have not been addressed in suicide research among sexual minorities to date" (p. 499). They reported neither mental disorder nor discrimination has been shown to explain the excess risk of suicide attempts among non-heterosexual people. A study by Skerrett, Kolves, and De Leo (2014) discovered that while LGB people who died by suicide had a higher incidence (65.7%) of interpersonal problems prior to death than their heterosexual counterparts (33.3%), they actually had *lower* levels of family conflict (5.7% to 17.1%).

Studies outside of Western culture appear to indicate that culture may play a significant role in this literature as well. Using an LGB sample from China, Shao, Ching, and Chen (2018) found that minority stress was not related to psychological maladjustment, whereas respect for parents and perceived parental support were associated with positive adjustment. The authors conclude that the minority stress model cannot be generalized to individuals living in cultural

contexts that emphasize family connections over one's sexual identity. This may have relevance for non-heterosexual persons who identify with conservative religious communities, many of whom adhere to less individualistic cultural values.

Research in this area is almost entirely reliant upon self-reports of *perceived* discrimination, and the relation of this to objective discrimination is not well understood. Self-report data make it difficult to tell how much of the association between perceived discrimination and well-being or psychological distress reflects the effects of perceptions of discrimination per se and how much is the effect of actual encounters with discrimination and negative treatment (Schmitt et al., 2014). Burgess, Lee, and van Ryn (2007) found that although perceived discrimination was associated with almost all indicators of poor mental health, adjusting for discrimination did not significantly reduce mental health disparities between heterosexual and LGBT persons, indicating that discrimination did not account for the disparity. Also supporting the notion that perceptions of discrimination may play a more prominent role than actual discrimination is research indicating minority stress theory can explain distress even among numerically and socially dominant groups, such as Christians (Parent, Brewster, Cook, & Harmon, 2018).

Other research suggests the link between perceived discrimination and health disparities may not hold for religiously affiliated sexual minorities (Barringer & Gay, 2017). A nationally representative study found that religiously affiliated sexual minorities are happier, regardless of whether their religious denomination is mainline Protestant (and affirms LGBT identity) or Evangelical Protestant (and condemns LGBT identity).

Alternatives to Minority Stress Theory

The relationship between sexual orientation-related stigma and discrimination to psychological and physical well-being among LGB persons is undoubtedly complex, and no single theory is likely to provide a universal explanation. Lick, Durso, and Johnson (2013) observed that the mechanisms linking sexual orientation-related stigmas to physical health outcomes remain poorly articulated and causality cannot be inferred. In spite of these uncertainties, minority stress theory (Meyer, 2003) has assumed a favored status in academic and policy discussions, including discussion related to prohibiting professional SOCE. This theory posits that experiencing or even fearing stigma specifically related to one's LGB identity arouses feelings of distress that can have profound consequences for the well-being of LGB persons. Opponents of change-allowing talk therapies often view them as inherently stigmatizing and discriminatory (and thus responsible for subsequent emotional and physical distress), but this is a dubious assertion given the substantial uncertainties surrounding minority stress theory.

Indeed, as Savin-Williams (2006) has observed, evidence for the causal pathway of this theory (i.e., sexual orientation to discrimination to mental and physical health disparities) is "more circumstantial than conclusive" (p. 42). McGarrity (2014) reported that LGB individuals are more highly educated than the general population, a finding not consistent with an unqualified minority stress position. She also indicated that the lower income levels of gay and bisexual men may not stem from discrimination but from their tendency to pursue "typically female" fields of study in

college. Another study found that components of minority stress predicted no more than 5% of non-heterosexual drug and alcohol usage (Livingston, Oost, Heck, & Cochran, 2014). Even if it were to be (and it clearly has not been) proven that change-allowing talk therapies with minors were a form of stigma, Wald (2006) asserted that, "While the presence of stigma is clear, the research does not find that it has a significant harmful impact on the children's mental health" (p. 399). Important alternative theories have been proposed to challenge or supplement the causal assumptions of the minority stress view.

Mediation Theories

Some theories with empirical support suggest that other factors indirectly mediate the pathways linking discrimination and stigma with disparities in LGB psychological health (Hatzenbuehler, 2009). Other theories assert that LGB discrimination and stigma may itself mediate the relationship between other factors that result in such disparities. In other words, specific sexual orientation discrimination or stigma may be minimally related or unrelated to psychological distress and physical health in the absence of certain intra- or interpersonal processes (Schumm, 2014). While many theoretically favored factors thought to influence LGB health disparities have been questioned (as noted above), several examples of other mediating factors can be provided.

Recent literature also finds that particular emotion/avoidant-based coping mechanisms used by people reporting same-sex attractions almost entirely account for the effects of this perceived discrimination (Whitehead, 2010). For example, the inability to regulate one's negative emotions was found to be a primary contributor to the pathway from sexual minority stressors and physical health symptom severity (Denton et al., 2014). In addition, differential rates of health problems resulted from sexual orientation-related differences in coping styles among men, with an emotion-oriented coping style mediating the differences in mental and physical health between heterosexual and homosexual men (Sandfort, Bakker, Schellevis, & Vanwersenbreeck, 2009). Passive coping style has been found to mediate mental health disparities between LGB and heterosexual youth (Bos et al., 2014) while emotion-focused coping (the ability to regulate negative emotions) mediated physical health disparities between adult LGB and heterosexual individuals (Denton et al., 2014). Rumination (the tendency to passively and repetitively focus on one's distress and distress-related circumstances) has also been found to mediate the relationship between stigma and distress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009).

Worries among sexual-minority youth concerning friendships and never finding a romantic partner have also been observed to mediate such disparities (Diamond & Lucas, 2004). Health disparities between gay and heterosexual men may also be mediated by the emotional and physical stresses of living with HIV/AIDS or other related physical ailments (Lick et al., 2013). In one study, disparities in heart disease, liver disease, digestive problems, and urinary incontinence disappeared after accounting for HIV status (Cochran & Mays, 2007).

Non-heterosexual Lifestyle Theory

This perspective posits that LGB lifestyles are inherently riskier than those of heterosexuals because of certain features

of LGB social communities (Vrangalova & Savin-Williams, 2014). Schumm (2014) has suggested that differences in conduct between non-heterosexuals and heterosexual persons rather than sexual orientation identity may lead to or reinforce discrimination. These behaviors may include antisocial behaviors, unsafe sexual practices, and drug use. For example, Hatzenbuehler, Keyes, & Hasin (2009) found that drug use as a psychiatric disorder increased over time for LGB persons in states that had *more* protective policies. Higher substance use may be due to many LGB communities being structured around bars and clubs (Trocki, Drabble, & Midanik, 2005, 2009).

Common Factors Theory

This theory asserts that the elevated health problems among non-heterosexuals could be directly or indirectly due to genetic or environmental "common causes" of both health risks and nonheterosexuality (Vrangalova & Savin-Williams, 2014; Zietsch, 2012). Gender nonconformity, divergence in behavior, personality, and identity from those typical of one's sex, are likely determined by the same genetic and neurodevelopmental or environmental factors as non-heterosexuality, and therefore may be linked to both victimization and mental health regardless of sexual orientation. Other personality traits may be implicated as common causes as well. Increased internalizing (e.g., self-harm) and externalizing risk behaviors (e.g., sexual risk-taking) may be due to direct or indirect shared genetic effects between non-heterosexuality and neuroticism or sensation seeking, rather than non-heterosexuality per se. Common causes could also be environmental. For example, to the extent the same environments (e.g., large cities, college campuses, night clubs) that provide opportunities for exposure to sexually arousing stimuli also provide opportunities for engagement in various risky behaviors or carry other health risks, this could be a common cause for both health risks and nonheterosexuality.

The review article by Vrangalova and Savin-Williams (2014) is particularly intriguing in that it focused on psychological and physical health disparities among mostly heterosexual individuals. The mostly heterosexual (MH) orientation is characterized by a strong presence of other-sex sexuality and a slight amount of same-sex sexuality. MH may comprise about 4% of men and 9% of women in the general population (Savin-Williams & Vrangalova, 2013). Because MH persons tend to view themselves and are viewed by others as essentially heterosexual in their sexual orientation and lifestyle, they are plausibly exposed to much less sexual orientation discrimination and stigma than LGB-identified persons. One study reviewed indicated that only 8% of MH teenagers reported experiencing sexual orientation-based discrimination. Yet Vrangalova and Savin-Williams (2014) reported that MH individuals are closer to bisexuals than heterosexuals in their health risks (see also Rosario et al., 2016). These authors further noted that people with exclusive opposite-sex or same-sex attractions may have less elevated health risks than individuals who experience any proportion of sexual attraction to both sexes. They concluded, "This raises the possibility that it is something about non-exclusivity in sexual attractions or lifestyles that is linked to negative health outcomes" (p. 437).

The existence of such variant theories to explain the relationship (or lack thereof) of stigma and discrimination to psychological and physical health disparities between

LGB and heterosexual persons argues strongly for the exercise of judicial restraint when making public policy that rests in part on such disparities. The pathways to elevated health risks among non-heterosexuals may certainly include discrimination and stigma, but the extent, causal direction, and mediation of such a relationship are currently far from understood. It is therefore both simplistic and unscientific for the Resolution to imply a causal link between the practice of professional change-allowing talk therapies and health disparities among youth.

Some Health Outcomes Are Likely Based in Anatomy More Than Stigma

In addition, some health risks, such as sexually transmitted diseases (including HIV) among gay men, may be influenced by stigma but are ultimately grounded in biological reality. A recent comprehensive review found an overall 1.4% per-act probability of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer, et al., 2012). The authors noted, "The 1.4% per-act probability is roughly 18 times greater than that which has been estimated for vaginal intercourse" (p. 5). Swartz (2015) found sexually transmitted infections other than HIV/AIDS in 35.6% of men who had sex with men compared to 6.6% of the matched population sample of men. CDC statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men has been more than 44 times that of other men (CDC, 2011). Young gay and bisexual men aged 13-29 accounted for 27% of all new HIV infections in 2009 and were the only group for whom new HIV infections increased between 2006 and 2009 (Prejean et al., 2011). In 2017, gay and bisexual men disproportionally accounted for 66% of all HIV diagnoses and 82% of diagnoses among males (CDC, 2019). Oswalt and Wyatt (2013) surveyed college students and found that while 69.5% of heterosexual males had never engaged in anal sex, only 10.8% of gay males had not engaged in this sexual behavior.

Sharing such information with prospective SOCE clients is not inherently manipulative but rather, when balanced with other considerations, constitutes an ethically obligated aspect of informed consent. The Resolution's proposal that the APA should suppress therapist speech conveying such accurate scientific information is unethical, is harmful, surely violates the First Amendment in the United States, would reveal that ideology triumphs over science in the APA, and would make crystal clear to the public that the APA cannot be trusted as a source of accurate scientific information.

SOCE Not a Proxy for Stigma or Discrimination

The lessening of stigma associated with "coming out" need not necessarily imply an affirmation of a gay, lesbian, or bisexual identity or of the enactment of same-sex behavior. SOCE practitioners often encourage the client's acceptance of his or her unwanted same-sex attractions and the disclosure of this reality with safe others as a potential aid in the pursuit of change or, in cases where change does not occur, behavioral management of sexual identity. This typically occurs when clients desire to live within the boundaries of their conservative religious values and beliefs.

While it is often assumed that conservative religious environments are stigmatizing and harmful for sexual minorities by definition, this is by no means a universal finding. Barringer and Gay (2017) conducted one of the few, if not

the only, sociological studies on the relationship between LGBT identity and religious affiliation. They noted, "Previous research finds that highly religious people tend to report higher levels of happiness, health, and civic engagement compared to less religious people" (Barringer & Gay, 2017, p. 77). Their nationally representative study of LGBT-identified individuals found that, overall, "LGBT respondents report a general feeling of happiness (.85) that is similar to that of the general population (.86) reported by the General Social Survey" (p. 85). There were, however, significant differences by religious affiliation.

> The results show that religious affiliation is a significant predictor of LGBT individuals' happiness. LGBT individuals who identify as Catholic, agnostic or atheist, or with no particular religious affiliation report lower levels of happiness compared to mainline Protestants. Surprisingly, no significant differences are found between mainline Protestants (whose church doctrine often accepts same-sex relations) and evangelical Protestants (whose church doctrine often condemns same-sex relations). (Barringer & Gay, 2017, Abstract)

Barringer and Gay (2017) observed, "those who report no religious affiliation or identify as agnostic or atheist together form the largest group of participants among the LGBT population" (p. 91). Questions arise as to whether some of them were never religious, and therefore they found it easier to identify as LGBT but do not have religious faith as a source of resilience. Or some may leave their faith and faith community when they identify as LGBT and may move to the LGBT community, but they also give up a very real potential source of happiness. A move or return to religious affiliation might reasonably be worthwhile to suggest among sexual minorities.

A number of research findings that apply to religiously disaffiliated sexual minorities—that is, that apply to most sexual minorities—may not unambiguously apply to those who are religiously affiliated and hold traditional values, findings on such variables as perceived discrimination, homonegativity, coming out, health disparities, and SOCE. Recent research on SOCE looks at participants who are largely or solely religiously unaffiliated (Bradshaw, Dehlin, Crowell, & Bradshaw, 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Flentje, Heck, & Cochran, 2013; Ryan, Toomy, Diaz, & Russell, 2018).

One study of black lesbian, gay, and bisexual young adults, 86% of whom were open about their sexual identity, found that "Participants who reported lower religious faith scores and lower internalized homonegativity scores reported the lowest resiliency, while those reporting higher religious faith scores and higher internalized homonegativity reported the highest resiliency scores" (Walker & Longmire-Avital, 2013, p. 1727).

Referral for change-allowing talk therapies therefore cannot be designated as a proxy for harm-inducing family rejection and stigma, as the proponents of ethical or legal bans and the authors of the Resolution seem to assume. Only a few studies have directly examined the link between family rejection and health risk among minors (Saewyc, 2011), and the derived findings can be contrary to expected theories, such as the discovery that same-sex attracted boys who participated in more shared

activities with their parents were *more likely* to run away from home and use illegal drugs than those who participated in fewer shared activities (Pearson & Wilkinson, 2013). The Ryan et al. (2018) study is the first of its kind in this arena, but with serious aforementioned limitations that make it little more than a non-generalizable pilot study. Thus, the Resolution or an ethical or legal ban on SOCE would unnecessarily and without scientific warrant eliminate the potential role of conservative religious values for ameliorating the effects of stigma in the context of change-allowing talk therapies. This would prevent clients from one means of prioritizing their religious values above their same-sex attractions when these factors are in conflict. The contention that a desire to modify same-sex attractions and behaviors can only be an expression of self-stigma reflects a serious disregard for and misunderstanding of conservative religious and moral values (Jones, et al., 2010).

Encouraging Same-Sex Behavior May Result in Risk-Justifying Attitudes

Finally, some research has raised the possibility some widely accepted theories germane to the discussion of stigma, discrimination, and health outcomes may, in fact, have gotten things backwards. A longitudinal study of gay and bisexual men by Huebner, Neilands, Rebchook, and Degeles (2011) found that,

> … in contrast to the causal predictions made by most theories of health behavior, attitudes and norms did not predict sexual risk behavior over time. Rather, sexual risk behavior at Time 1 was associated with changes in norms and attitudes at Time 2. These findings are more consistent with a small, but growing body of investigations that suggest instead that engaging in health behaviors can also influence attitudes and beliefs about those behaviors. (p. 114)

Thus, safe-sex norms and attitudes did not lead to reduced unprotected anal intercourse; rather, participants' engagement in such HIV-risk behavior appeared to change how they thought and felt about the behavior and enhanced their willingness to engage in it. Such findings raise serious concerns about the impact of the proposed Resolution and ethical or legal bans of SOCE, in that a law, ethics code, or policy which only allows for the affirmation and ultimate enactment of same-sex attractions may in fact increase HIV risk and negative health outcomes for some minors or adults who might otherwise have sought change-allowing talk therapies. Engaging in homosexual behavior in adolescence or young adulthood has been linked with an elevated prevalence of many serious risk behaviors and emotional problems (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Outlaw et al., 2011). In addition, experiencing rape or sexual assault before the age of 16 has been strongly associated with belonging to any non-heterosexual group (Wells et al., 2011; Laumann, Gagnon et al., 1994).

While stigma and discrimination are real concerns, they are not universal explanations for greater psychiatric and health risks among sexual minorities, some of which are likely to be grounded in the biology of certain sexual practices. Moreover, the effects of stigma and discrimination can be addressed significantly within change-allowing talk

therapies for many clients, though this is no doubt hard to comprehend for those not sharing the religious values of SOCE consumers. There is no longitudinal research involving consumers of change-allowing talk therapies that link the known effects of stigma and discrimination to the practice of SOCE. SOCE is simply *ipso facto* presumed to constitute a form of stigma and discrimination. This is in keeping with the persistently unfavorable manner in which change-allowing talk therapies are portrayed by the mental health associations. Change-allowing talk therapy practitioners and consumers are associated with poor practices as a matter of course (Jones, et al, 2010; APA, 2009, 2012). This arguably is a form of stigma and discrimination toward licensed practitioners of SOCE, who ironically have developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to consumers of change-allowing talk therapies (Alliance for Therapeutic Choice and Scientific Integrity (ATSCI), 2018). The APA may reduce such presumed harm by allowing practitioners of ethical, change-allowing therapies to present ethical guidelines for change-allowing therapies practitioners at APA conventions or by other means, such as professional articles in APA periodicals or webinars in APA venues.

The APA Should End Institutional Prejudice Against Traditional Faiths

It should not be assumed that homonegativity in a religious faith causes health disparities for a client and another set of religious beliefs would be more beneficial. A study by Barringer and Gay (2017) of happiness in a nationally representative sample of LGBT individuals reported:

> This article analyzes the impact of religion on reported levels of subjective well-being (general happiness) among lesbian, gay, bisexual, and transgender (LGBT) adults. Although previous studies find religious affiliation to be a significant predictor of subjective well-being among the general population in the United States, limited quantitative research investigates general happiness among sexual and gender minorities. This study augments the existing literature by using a national survey of LGBT adults conducted by the Pew Research Center in 2013. The results show that religious affiliation is a significant predictor of LGBT individuals' happiness. LGBT individuals who identify as Catholic, agnostic, or atheist, or with no particular religious affiliation report lower levels of happiness compared to mainline Protestants. Surprisingly, no significant differences are found between mainline Protestants (whose church doctrine often accepts same-sex relations) and evangelical Protestants (whose church doctrine often condemns same-sex relations). (Barringer & Gay, 2017, Abstract)

Similarly, a large, population-based study of Mormons concluded,

> What this study does suggest is that, however they do it, the LGB Mormon population's reconciliation of particular facets of their sexual and religious identities does not lead them to having discernibly worse mental or physical health than their non-LBG Mormon and LGB non-Mormon counterparts. (Cranney, 2017, p. 741)

A recent study of a large convenience sample of Utah Mormons conjointly conducted by affirmative and change-allowing researchers together (Lefevor, Sorrell, et al, 2019) also found no difference between religiously conservative Mormons who identified as same-sex attracted and religiously progressive Mormons or former Mormons who identified as LGBT in measures of anxiety, depression, substance abuse, flourishing, life satisfaction, or physical health. Yet the conservative Mormons engaged in less same-sex sexual behavior, scored higher on homonegative views, and were less open about their sexual attraction. Both groups were equally resolved in how they integrated their beliefs about same-sex sexuality and their religious beliefs. They achieved integration and flourishing by contrasting paths, perhaps facilitated by contrasting community support.

> Our results suggest that SSA Mormons likely received greater support from their religious communities, whereas LGBQ Mormons may have received more support from LGBQ communities. (Lefevor, Sorrell, et al, 2019, p. 20)

The authors suggested homonegativity in religious conservative sexual minorities may not measure feelings about self.

> Thus, especially among our religious sample, internalized homonegativity may represent the movement toward or away from conservative religious values rather than specific beliefs about self (Rosik, 2007). Indeed, in other non-LGBQ identified religious samples, internalized homonegativity has also not been associated with increased shame or decreased wellbeing (Hallman, Yarhouse, & Suarez, 2018). (Lefevor, Sorrell, et al, 2019, p. 19)

> Internalized homonegativity is inherently an LGBQ concept….It is unclear if a construct such as internalized homonegativity can be meaningfully applied to individuals who reject an LGBQ sexual identity label because they may identify as straight…. (Lefevor, Sorrell et al, 2019, p. 6)

> We encourage researchers and therapists to take a thorough intersectional approach when working with or studying sexual minority Mormons to better manage bias and understand the participants/clients. (Lefevor, Sorrell et al, 2019, p. 21)

Another recent study conjointly conducted by affirming and change-allowing

researchers found sexual minorities who live in relationship options that are consistent with conservative faiths—such as opposite-sex relationships or celibacy accompanied by social relationships—can experience satisfaction that is real (Lefevor, Beckstead, et al, 2019).

Research on psychology and religion in sexual minorities almost always overlooks non-LGB identified and satisfied religiously conservative sexual minority folks, so it should not be generalized to them. When studies include them, as these studies do, or are taken from large, representative samples, the results are often not in keeping with the conventional APA wisdom.

Numerous sources indicate contemporary SOCE is primarily about clients and therapists of conservative beliefs.

> From our survey of recent publications and research, most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs (e.g., S. L. Jones & Yarhouse, 2007; Nicolosi et al., 2000; Ponticelli, 1999; Shidlo & Schroeder, 2002; Spitzer, 2003).

The biased focus of the APA approach to sexual minorities of conservative faiths comes from policies and ethical standards being decided for conservatives by committees of progressives— people who do not represent them and who may even dislike their faith. Denying representation is not consistent with a nondiscrimination policy. When only progressive minority members are permitted representation in setting policies in mainline professional organizations and conservative minorities are restricted, a large closed circle of these progressive organizations can be expected to reach a progressive consensus, but such a consensus is not a true professional consensus and should not be passed off to the public as professional consensus. The committee writing the updated APA resolution on SOCE, which all indications suggest is primarily about therapy for people of conservative faiths, should unambiguously include conservatives in order to bring about an actual consensus of professionals and a resolution that meets the needs not only of progressive people who identify as LGBT but also the needs of sexual minorities of conservative beliefs and values. Otherwise, there is danger the Resolution will be one more triumph of progressives marginalizing conservatives in the APA that advertises for conservative professionals to leave or not join the APA, deprives conservative patients of treatment they need and deserve, and contributes to the polarization of the public.

The Resolution consistently presents traditional religious beliefs about sex as "societal ignorance," "prejudice," bad, unhealthy, and something to be avoided, left, and overcome. The Resolution, Report, and *APA Monitor* article on model affirmative therapy indicates psychologists should help clients and parents modify these conservative beliefs whenever possible. It indicates the only way someone could possibly be motivated to live by them would be out of coercion, externalized "conflicts" or "lack of information." Living according to a progressive worldview and conducting research largely on participants who share that worldview and interpreting it through the lens of a progressive worldview is having the right "information" that will lead to living the right way. For example, the Resolution says,

> WHEREAS, societal ignorance and prejudice about same-gender sexual orientations places some sexual minorities at risk for seeking sexual orientation change due to personal, family, moral or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje, Heck & Cochran, 2014; Haldeman, 1994; Hatzenbuehler, Pachankis, & Wolff, 2012; Mallory, Brown, & Conron, 2018; Ponticelli, 1999; Shidlo & Schroeder, 2002;)

Making policies based on progressive, secular, agnostic, or atheistic worldviews on sexual orientation and religion while censoring or excluding researchers of traditional worldviews does not result in objective science or information. The predictably biased result is being used to bully sexual minorities of traditional faiths, their parents, and their therapists. The Resolution adjudicates on religious beliefs and practices. Its prejudicial view of traditional faiths violates the tenants of the APA:

> "[P]sychologists are encouraged to recognize that it is outside the role and expertise of psychologists as psychologists to adjudicate religious or spiritual tenets"; APA disavows prejudice directed against individuals and "condemns prejudice directed against individuals or groups, derived from or based on religious or spiritual beliefs" (APA, 2008a; 2008b);

The APA ought to add to its discrimination policy that it disavows prejudice derived from progressive versus conservative beliefs.

> WHEREAS, APA affirms that psychologists do not discriminate (APA, 1998, 2000, 2002, 2003, 2005, 2006a, 2008b, 2017a)
>
> [Psychologists] strive to prevent bias from their own beliefs from taking precedence over professional practice and standards required by psychological science (APA, 2008b; 2009);

Nowhere in the Resolution is the concept that some who experience same-sex sexuality *want* to change their attractions or behavior to live in accordance with their faith because they see the beauty of their faith, and their desire comes from the heart. The Resolution repeatedly presents religious motivation as external to the individual, coerced, and merely fear-based. It habitually presents traditional religious beliefs and practices about sexual orientation from a pejorative stance. While some individuals, such as apparently the authors of the Resolution, hold such a negative view of traditional faiths, the utter failure to recognize the existence of any other perspective is telling and is religious prejudice and discrimination in itself. The Resolution violates all its many repetitions of APA statements against religious prejudice and discrimination.

People commonly seek change allowing therapy for a variety of personal reasons that are not external forms of coercion. Examples include: (1) Being gay did not work for them. They identified as LGB and had same-sex experiences, but ultimately, they did not find

being LGB fulfilling. (2) It does not align with their values and beliefs that should be respected. (3) They feel same-sex attraction or behavior was caused for them by childhood sexual abuse or other trauma or painful experiences, and they feel it does not represent their true self. (4) Same-sex sexuality is endangering their opposite-sex marriage and family that they want to protect and save, or they aspire to such a relationship, because they love their opposite-sex spouse and children or because they want both to procreate and to raise children with their future spouse. All these reasons should respected.

The APA has Done a Poor Job Educating the Public that the APA has Changed its View about Same-Sex Sexuality

It is important to note that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and "there is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the causes of sexual orientation differently:

> "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, 2008a; emphases added).

The APA Handbook of Sexuality and Psychology (2014), with the APA's "imprimatur" and declaration as "authoritative," has moved beyond the 2008 statement saying "many think" to more definitively asserting,

> Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors....A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful. (*1*:583)

It also said childhood sexual abuse has "associative and potentially causal links" to having a same-sex partner (*1*:609-610). In addition, and as we have previously quoted, the *APA Handbook* says sexual attraction, behavior, and identity all fluctuate or change for many adolescents and adults (*1*:636, 562, 619).

Yet the same year (2014) that the *APA Handbook* published statements that sexual orientation is not biologically determined, has psychoanalytic causes, is potentially causally linked to CSA, and changes for many, the APA was telling courts otherwise. Gilfoyle, APA's general counsel at the time, published in the "2014 Annual Report of the American Psychological Association" (Gilfoyle, 2015, p. 527) that the APA filed "nine briefs" in 2014 that presented "an accurate summary of the current state of

scientific and professional knowledge concerning sexual orientation…including that homosexuality is…resistant to change…."

Further, as recently as March 2017, the *Monitor on Psychology*, one of the publications of the American Psychological Association that is disseminated to all APA members featured for continuing education credit an article showcasing model affirmative therapy called, "How Should a Psychologist Advise a Heterosexual Man Who Has Sexual Thoughts About Men?" (Novotney). It presented the case of a man, married to a woman, whose same-sex thoughts conflicted with his faith. The *Monitor*'s model therapy article reports advice from Glassgold, the chair of the APA Task Force Report of 2009, in which she is still promoting an outdated APA position from 1998. "Glassgold notes that in these types of cases it can also be helpful to share information with the patient on the scientific basis of homosexuality and sexual attraction pointing to research showing that it is thought to be primarily biological" (p. 41). This view aligns with the "key" view that sexual orientation is immutable on which the task force "built" its conclusion. One may wonder how deeply the unscientific view that sexual orientation is primarily biological and fixed is influencing the policies on sexual orientation and therapy for the APA and beyond, given that the 2009 APA resolution on SOCE was based on the APA task force Report, given that the chair of that task force co-coordinated a consensus statement of professional organizations in 2015, and given that in the APA's instruction to therapists for model affirmative therapy, she is promulgating this biological view to therapists to in turn promulgate to clients in 2017. Promoting inaccurate scientific information, if knowingly done, is unethical according to the APA ethics code (APA, 2017). Yet APA dissemination of unscientific information appears to be what has come of the APA leadership allowing a one-sided lobby to silence dissenters and dominate policy. The APA leadership needs to correct this if it is to restore itself as a source of accurate scientific information. Turning this around will require reestablishing representation of viewpoint diversity.

The *Monitor*'s unethical advice to give a client the scientifically inaccurate and potentially harmful information that sexual orientation is largely biologically determined will take all hope for change away from the man. There is no indication the contributors to the article considered whether the man could be attracted to both sexes or be mostly heterosexual and in an opposite-sex marriage by preference, not only because acting on same-sex thoughts would conflict with his faith. The assumption appears to be that if he has any same-sex thoughts, his attractions are exclusively homosexual and fixed, and he would be happier living as a homosexual man. If he decides to stay in his opposite-sex marriage, it appears to be assumed he will be miserable, but a dutifully ethical therapist will accept his decision.

The entire impetus of the *Monitor* model therapy article appears to be for the therapist to guide him to change his religious beliefs and place of worship and encourage him to consider what he thinks would happen if he acted on his same-sex thoughts (all done very professionally and with respect for his decision). There is little concept of how a therapist who understands his traditional faith can crucially help him from *within* his traditional faith, for example to sort through feelings of guilt, shame, or fear around opening up all of his feelings to God and others for help with them. If he feels he needs to change his church, there is no concept presented for his choosing among churches that yet share his faith to find one that offers more supportive help. Simultaneously taking

away his hope for sexual attraction mutability, his religious faith, his religious community, and his family is potentially a recipe for suicidality. *This is harmful "conversion therapy."* An alternate approach should include exploring whether he is attracted to both sexes or mostly heterosexual, may be in an opposite sex marriage by preference, not only because of his faith, and may have capacity for fluidity over time which could be discussed with him, giving him hope. Factors thought to affect fluidity could be shared with him, such as being in an opposite-sex relationship and an ideological context that supports his goal (for example in a group or church) (Hu et al., 2016; Diamond, 2008; Diamond & Rosky, 2016, Manley, 2015).

He could be offered the same treatment a man would be offered if he were attracted to other *women* in conflict with his faith and marriage, such as marital and individual therapy. Why he is tempted to stray *now* could be explored. Is he experiencing obsessive thoughts? He could be offered the option to join a support group for others like himself who share his faith and whose goals are to live aligned with their faith and to save their marriage and family. Affirmative therapy, individually or in a group that rejects or is "neutral" or tolerant toward such goals, is not interchangeable with individual or group therapy that is open to change and values such goals.

And, in light of research on potential causes of same-sex sexuality, an assessment for possible treatable causes of his same-sex attraction and behavior should be offered and appropriate treatment for such potential factors offered, if appropriate, with discussion of possible outcomes of change, partial change, or not changing and how he would deal with such outcomes. Always, any shame must be addressed in order to decrease it and in order to increase the possibility of his being able to engage in therapeutic exploration and change.

We can hope the APA will now put an end to the falsehood that same-sex sexuality is primarily biologically caused and is uniformly resistant to change. By perpetrating this falsehood for 20 long years, the APA has made itself appear either scientifically inept or deceitful for political purposes. It has diminished its credibility as an institution that can be trusted to provide "accurate scientific information" when it comes to political social issues.

The APA has made minimal effort to publicize the change in its official position on the causation of same-sex orientation or to correct the accompanying popular misconception–often promoted by the media–that persons with same-sex attractions are simply "born that way" and "can't change." It is difficult not to perceive this as significant professional neglect.

It also raises the question as to whether this neglect has been allowed to go on for the purpose of political advocacy. Diamond and Rosky (2016) have urged political activists to drop the unscientific notions that individuals who experience same-sex sexuality are born that way, cannot change, and cannot choose, saying such exaggerated science is no longer needed in America.

Unmasking the reality that exaggerated science has been perpetrated for political advocacy raises skepticism. Do the authors of the Resolution believe suppressing speech about the well-known health risks of same-sex sexuality and prolonging exaggerated science claiming immutability and harm in therapy are still needed for political purposes in America?

Professional Organization Resolutions are Not Scientific Evidence

The APA's own statements on sexual orientation have changed over time. Position

statements of professional organizations are not fixed or immutable. As the history of science itself makes clear, scientific consensus often enough turns out to be incomplete or incorrect. It changes and is unreliable. The APA's resolution on SOCE may be the only American professional organization statement that purports to be based on a review of the research. It was, however, based on erroneous or seriously questionable "key scientific research findings" that same-sex sexuality is immutable through life events and is not caused by family dynamics or trauma. The 2009 APA resolution on sexual orientation change is based on the APA Task Force Report that is based on outdated scientific beliefs and biased anecdotal, not scientific, evidence. Professional organization position statements are not scientific evidence. They are opinion resulting from worldview and lobbying of activist members in these guilds.

Professional SOCE Bans Claim Aversive Practices, Target Speech

The Resolution claims aversive methods and torture are currently being used in SOCE. For example, it says,

> The United Nations considers some SOCE to rise to the level of human rights violations, labeling SOCE "abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment" (United Nations Human Rights Commission [UN HRC], 2013).

Also,

> WHEREAS, the United Nations states that "conversion" therapy, when forced or otherwise involuntary, can breach the prohibition on torture and ill-treatment (UN HRC, 2015),…

The idea that ethical client-directed talk therapy using evidence-based methods and well-established mainstream practices used by mental health professionals around the world is "torture" appears to be based on a claim that the U.N. considers some SOCE to be torture. This assertion wildly misrepresents the facts. The reality is that there is no U.N. binding resolution that even mentions sexual orientation, much less sexual orientation change efforts or "conversion" therapy. The supposed U.N. citations are to a single individual, Juan Mendez, who has submitted papers (March 22, 2011; Feb. 1, 2013) to the Human Rights Council, a subsidiary U.N. committee that represents merely 47 member states. The only recognition these opinion pieces received in the U.N. was that they were received and filed by this subsidiary committee. The author of this opinion piece cited the Yogyakarta Principles (Correa & Muntarbhorn, 2006), a radical advocacy document that was aggressively and strongly rejected by U.N. member states. There is nothing here that represents the United Nations. If the final Resolution cites this bogus claim, it will underscore that the APA is not a reliable source of accurate information about change-allowing therapies, and it is now peddling false and misleading advocacy opinions as though it were fact. If, after we have now exposed this foolish U.N. claim, the final Resolution maintains it, it will broadcast to the public that the APA is

either deceived or deceiving and is not to be taken seriously.

The APA Task Force Report said behavioristic and aversive methods were predominantly used in the 1960s and early 1970s, making their use 40 to 50 years ago, and the Report said contemporary change-allowing therapists do not use them (2009, pp. 22, 82).

There is now clear evidence from state legislative proceedings that the intent of banning therapy is to stifle therapist speech and not certain aversive practices. Across the country where ban legislation for minors or adults has been debated, politicians are hearing testimonials that directly or by implication associate SOCE provided by licensed therapists with painful aversive techniques such as shocking genitals, chemically inducing vomiting, taking ice baths, and the like. This caricature of contemporary change-allowing talk therapies as promoting such child abuse is both disingenuous and slanderous, as was revealed in the legislative process surrounding proposed therapy bans in the states of Washington in 2015 and Utah in 2019. In both instances, amendments initiated or backed by change-allowing therapists were made in committee that would have preserved a legal prohibition on the harmful aversive techniques but would have specially protected therapist speech. In the Utah example, the amendment would even have penalized guarantees of "a complete and permanent reversal in the patient or client's sexual orientation."

Nevertheless, despite the prospect of bipartisan support for these bills, proponents pulled the legislation, complaining they did not go far enough despite their targeting of the same aversive practices that were prominently mentioned as a basis for these bans (Backholm, 2015; "Watered down anti-conversion therapy bill," 2019). Particularly telling were the comments by University of Utah College of Law professor Clifford Rosky, who developed the original ban bill in Utah, as reported in the local gay press:

> "Licensed therapists haven't been doing electric shock therapy and adversant practices in decades," Rosky continued. What they do these days, he said was talk therapy. "As we know, words are just as damaging to children." (Backholm, 2015)

Clearly then, proponents of change-allowing talk therapy bans have known all along that allowing abusive aversive practices to be associated with contemporary professional SOCE is a fundamentally dishonest political maneuver. Politicians and judges need to hear from ban proponents examples of what specific words change-allowing talk therapy practitioners say to minors that creates damage on a par with electroshocking their genitals.

Are State Regulatory Boards Doing Their Jobs?

Statistics from the Williams Institute are being widely disseminated regarding the prevalence of "conversion therapy" (CT) (Mallory, Brown, & Conron, 2018). They claim that nearly 700,000 adults have received CT, and 350,000 were adolescents when they experienced CT. Furthermore, they claim that 20,000 youths ages 13-17 will receive CT from a licensed therapist before turning 18. These are stunning statistics, but the study methodology raises some serious questions about their validity as applied to change-allowing talk therapies. The study utilized questions

from the Generations Study, in particular the question, "Did you receive treatment from someone who tried to change your sexual orientation (such as try to make you straight/heterosexual)?" followed by an option for indicating whether the provider of treatment was a health care professional. Not only is the retrospective self-report nature of the survey problematic, given the likely need for participants to recall events from decades earlier, but "treatment" is left undefined and is so nebulous that one can gain no idea about the frequency or seriousness of the treatment techniques (encompassing anything from a felt sense that the therapist preferred heterosexuality on the one end to the application of electroshock aversive procedures on the other end). The definition of "health care professional" also is nebulous and does not give us insight into whether the professional was a licensed mental health professional. Furthermore, the survey included only LGBT-identified persons, which by definition would include a preponderance of individuals who had not experienced change. Although one might reasonably surmise these individuals would be less likely to have experienced positive benefits from their therapy, this question was not asked and hence the degree of distress coming from these treatments is not known and assertions to the contrary are mere speculation. It is much more plausible that the non-LGBT identified persons with same-sex attractions and behaviors who were excluded from the survey would have benefited from their change-allowing therapies, but again, we cannot ultimately know from the study what degree of harm or benefit any non-heterosexual participant experienced.

If the William Institute's numbers are not in some manner inflated, then this is bad news indeed for state regulatory agencies. The study suggests that some contemporary "…practitioners have also used aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks…." Even if only 1% of the tens of thousands of minors the Williams Institute indicates have undergone or are undergoing SOCE with a licensed therapist have been subjected to these aversive practices, it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. Strikingly, Drescher et al. (2016) noted, "To our knowledge, there have been no formal actions by a regulatory body against a provider for engaging in conversion therapy." Something has to give. Either the William Institute numbers do not reflect accurately upon practitioners of change-allowing talk therapies, or the state regulatory agencies are either negligent or incompetent, or licensed practitioners of change-allowing therapies (whatever their number) are conducting themselves in an ethical and professional manner.

Our experience suggests the last option to be by far the most probable means of understanding the disconnect between the William Institute's numbers and the lack of any therapists having lost their license for unethical SOCE-related conduct. This raises questions for the proposed APA Resolution recommendation for ethical (or nearly ethical) or legal bans: Are these bans a solution to a problem that does not exist for licensed therapists? If you believe otherwise, should you not focus attention on overhauling state regulatory agencies rather than usurping their mandate to oversee mental health professionals? Why the need to "accelerate the regulatory process," as some activists have been known to say? State regulatory boards exist and are funded for the purposes of addressing exactly the kinds of

unacceptable aversive practices ban proponents claim are occurring with some licensed SOCE providers. It is imperative any concerns along these lines be addressed by a state regulatory committee of other therapists. This committee will understand the nuances of psychotherapeutic work and hence be in a position to accurately determine genuine malpractice. Given that mental health professionals who engage in change-allowing therapies have expended great amounts of time and money on their education and careers and have much to lose, genuine justice demands any questions about their therapy-related speech be adjudicated by their professional peers in state regulatory agencies, not by a sweeping Resolution, politicians, judges, and civil juries.

Concluding Statements

There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and adults and see change-allowing therapies as a valid option for psychological care, while simultaneously affirming the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against professional SOCE, the information in the present comment should be sufficient to question the scientific (not to mention constitutional) merits of the proposed APA Resolution.

To summarize our main points:

(1) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as the Report or Resolution purports it to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists as pertains to sexual orientation research.

(2) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery as pertains to SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(3) An impressive body of scientific data indicates that non-heterosexual sexual orientations should not be viewed as always immutable but are often though not always fluid and subject to change, especially among youth and young adults. Assertions to the contrary should be considered in light of Diamond and Rosky's (2016) observation that, in spite of its scientific inaccuracy, "Some advocates clearly believe that immutability claims are necessary to advocate effectively for sexual minorities" (p. 372).

(4) The role of stigma and discrimination on negative health outcomes among non-heterosexual identities is real but provides only a small and partial understanding of these concerns. Most importantly, applying this literature uncritically to change-allowing therapies is scientifically and ethically dubious. The proper course of action for authors of the Resolution, politicians, and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not place a ban on its

professional practice that supersedes existing regulatory oversight and may create unintended consequences for licensed therapists who work with non-heterosexual clients.

As this comment on the proposed APA Resolution has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA task force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the task force noted, the prevalence of success and harm from SOCE cannot be determined at present, and recent SOCE research does not advance the field sufficiently to provide a scientific basis for an ethical or legislative ban. Anecdotal accounts of harm, which are a focal point of attention by supporters of bans as in the Report and Resolution, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal level. While such "hearsay" evidence is "not nothing," it is negligent, if not fraudulent, that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better-documented claims that experiences of SOCE were "beneficial," and were "not harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefits from change-allowing talk therapies (see http://www.voicesofchange.net/).

Furthermore, as observed earlier, accounts of harm cannot tell us if the prevalence of reported harm from change-allowing therapies is any greater than that from psychotherapy in general.

The normative occurrence of spontaneous change in sexual orientation among youth and adults, the nontrivial degree of choice reported by some in the development of sexual orientation, and the questionable blanket application of the literature on stigma and discrimination to SOCE further bring into question the appropriateness of the proposed Resolution. Sexual orientation is not a stable and enduring trait among youth or adults, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors or adults. Granted, high-quality research is needed to confirm clinical reports of change. However, it should be mentioned in this regard that the Resolution would make further research on change-allowing talk therapies with minors impossible where enforced, despite the APA task force's clear mandate that such research be conducted (APA, 2009).

Any genuine harm that results from SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. It is highly questionable and unlikely that the tangible, prosecutable harms from SOCE are as widespread as ban sponsors claim. To repeat: if such harms did exist, why have we heretofore not seen SOCE practitioners losing their licenses and mental health association memberships in droves? The Resolution is an overreach that takes an overly broad and absolute approach to SOCE harm and success, despite evidence suggesting age, gender, and non-

heterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by ethically or legally banning therapy, a distinction the Resolution does not make.

Proponents of bans reason that because homosexuality is no longer considered to be a disorder, providing change-allowing talk therapies to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, career distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention supporters of bans give to SOCE again hints at political advocacy rather than science as a primary inspiration.

The religiously conservative faith community will not be well served if change-allowing talk therapy with minors is judged *never* to be an appropriate modality for psychological care, especially when the affirmative interventions include the correction of the client's "false assumptions." Should a court agree with this line of argument, then a court is unconstitutionally taking a stand on the validity of certain forms of religious belief. By implying that there is always a better method than any form of SOCE, the authors of the Resolution presume to know what form of psychological care for unwanted same-sex attractions and behaviors is best for the religiously motivated minor clients and their parents or adult clients. Neither the courts nor the professional associations should be substituting their judgment for that of a 17-year-old who is calculating a cost-benefit analysis in deciding whether to undergo change-allowing talk therapy, understanding through informed consent that fluidity in unwanted same-sex attractions may not occur. The APA is quite clear that it supports the competence of a 17-year-old girl to give consent to an abortion. Why does the 17-year-old lose competence when it comes to change-allowing talk therapies? Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b). Is it reasonable that 17-year olds who experience themselves to be the wrong biological sex be allowed to take puberty blockers and cross-sex hormones that render them permanently sterile and may foreclose sexual function for life, surgically remove breasts, alter genitalia, and become a medical patient for life while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of high-quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne, et al., 2011).

The task force Report (APA, 2009), and the mental health associations that subsequently relied on it for their resolutions on SOCE, provide one viewpoint into research and reasoning that likely has some merit but must be considered incomplete and therefore not

definitive enough to justify a complete ban on change-allowing therapies with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Duarte et al., 2015; Redding, 2001), which has an inhibitory influence on the production of scholarship in controversial areas such as change-allowing talk therapies that might run counter to preferred world views and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> "In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons…This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board)" (p. 90).

Such diversity is precisely what is lacking currently in professional mental health organizations and their associated scientific communities as regards the study of contested social issues related to sexual orientation, including SOCE (Duarte et al., 2015; Wright & Cummings, 2005). If this were not true, it would be hard to understand how the American Psychological Association's leadership body—the Council of Representatives—could vote 157-0 to support same-sex marriage (Jayson, 2011). Likewise, it would be hard to understand how the leadership of the National Association of Social Workers could endorse a total of 542 candidates in federal elections between 2014 and 2018—all of whom were affiliated with the Democratic Party (NASW, 2018). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011).

The APA lost 10% of its members between 2008 and 2013 and now represents less than 44% of psychologists in America (Robiner, Fossum, & Hong, 2015). The American Medical Association now represents less than 20% of physicians in the country. These downward trends have in part come about due to these associations taking left-of-center positions on several social and policy issues, alienating conservative members and leading many of them to disaffiliate. The APA appears to be especially alienating religiously identified members, given that the APA division with the greatest membership loss was the Society for the Psychology of Religion and Spirituality, which lost over 34% of its members during the 2008-2013 period. It is evident from these kinds of statistics that, when it comes to socially contentious issues such as change-allowing talk therapies, the mental health and medical associations likely do not speak for many of those professionals who practice in their respective fields.

To repeat a final time, a truly scientific response to the concerns of the authors of the Resolution would be to encourage bipartisan research into SOCE with minors or adults that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. Change-allowing talk therapy practitioners

take seriously their responsibility to do no harm and would assuredly embrace such an opportunity (Jones, et al., 2010). Were proponents of the Resolution not playing a winner-take-all approach to the issue of professional SOCE, there would undoubtedly be substantial ground both sides could agree upon that would address concerns regarding alleged harms and reported benefits from change-allowing talk therapies. Unfortunately, the approach taken by the proposed APA Resolution represents only one (ideological and legislative) perspective on how to best address the considerations that come with the psychological care of unwanted same-sex attractions and behaviors. It is therefore a scientifically unsupportable, and therefore unjust, violation of the rights of current and potential change-allowing talk therapy consumers, their parents, and their therapists.

Therefore, we recommend what we believe is a better path, a conjoint effort by affirmative and change-allowing researchers to conduct research together into the safety and efficacy of SOCE and a conjoint committee of affirmative and change-allowing therapists to come to policies based on a true professional consensus that meets the needs of sexual minorities, their families, and their therapists of varying world views and therapy goals.

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APA Proposed Resolutions on "Gender Identity Change Efforts" and "Sexual Orientation Change Efforts" Raise Serious Legal Concerns for the Organization and Its Members

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In this legal comment on the American Psychological Association's (APA) draft of resolutions on sexual orientation and gender identity change efforts (SOCE and GICE), Mary McAlister of Liberty Council raises several concerns. These include (a) free speech concerns, (b) the biased sources the APA relies on for their analyses, and (c) the legal peril the resolutions create for the APA's accrediting programs. She cautions the APA not to adopt ideologically based regulations that actually contradict the APA's core principles.

Keywords: Legal issues, SOCE, GICE, resolutions, American Psychological Association

The draft APA Resolutions on "Gender Identity Change Efforts" ("GICE") and "Sexual Orientation Change Efforts" ("SOCE") raise significant legal concerns for the APA and its members. The APA's position as a gatekeeper for accreditation of university programs for psychological professionals means that these concerns are not merely academic, but could directly and adversely affect the organization, its members, and all psychological professionals who seek licensure.

Numerous states and municipalities have enacted statutes and ordinances banning so-called "conversion therapy" for minors, and some have attempted to enact laws against such therapy for adults under the guise of "consumer fraud." The "conversion therapy" bans for minors have been based almost entirely on two federal court cases that upheld such bans against First Amendment challenges, *Pickup v. Brown,* 740 F. 3d 1208 (9th Cir. 2014), and *King v. Governors of New Jersey,* 767 F. 3d 216 (3d Cir. 2014).

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However, the United States Supreme Court has called those decisions into question, which seriously erodes the entire legal foundation for these bans.

On June 26, 2018, the United States Supreme Court issued its opinion in *NIFLA v. Becerra*, 138 S. Ct. 2361 (2018), which reversed Ninth Circuit Court of Appeals decisions regarding California's Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT Act). In that decision, the Court abrogated the *Pickup v. Brown* and *King v. Governors of New Jersey* decisions as improperly infringing on the right of free speech protected by the First Amendment to the United States Constitution. California legislators had relied upon the *Pickup* ruling to justify the FACT Act, just as several states and municipalities have used *Pickup* and *King* to justify enacting statutes and ordinances banning "conversion therapy" for minors.

In the *NIFLA* decision, Supreme Court Justice Clarence Thomas, writing for the majority, rejected the Ninth Circuit's analysis of the First Amendment in *Pickup* and the similar analysis adopted by the Third Circuit in *King*:

> Some Courts of Appeals have recognized "professional speech" as a separate category of speech that is subject to different rules. See, *e.g., King* v. *Governors of New Jersey*, 767 F. 3d 216, 232 (CA3 2014); *Pickup* v. *Brown*, 740 F. 3d 1208, 1227–1229 (CA9 2014); *Moore-King* v. *County of Chesterfield*, 708 F. 3d 560, 568–570 (CA4 2014). These courts define "professionals" as individuals who provide personalized services to clients and who are subject to "a generally applicable licensing and regulatory regime." *Id.*, at 569; see also, *King*, *supra*, at 232; *Pickup*, *supra*, at 1230. "Professional speech" is then defined as any speech by these individuals that is based on "[their] expert knowledge and judgment," *King*, *supra*, at 232, or that is "within the confines of [the] professional relationship," *Pickup*, *supra*, at 1228. So defined, these courts accept professional speech from the rule that content-based regulations of speech are subject to strict scrutiny. See *King*, *supra*, at 232; *Pickup*, *supra*, at 1053– 1056; *Moore-King*, *supra*, at 569.
>
> But this Court has not recognized "professional speech" as a separate category of speech. Speech is not unprotected merely because it is uttered by "professionals." This Court has "been reluctant to mark off new categories of speech for diminished constitutional protection." *Denver Area Ed. Telecommunications Consortium, Inc.* v. *FCC*, 518 U. S. 727, 804 (1996) (KENNEDY, J., concurring in part, concurring in judgment in part, and dissenting in part). And it has been especially reluctant to "exemp[t] a category of speech from the normal prohibition on content-based restrictions." *United States* v. *Alvarez*, 567 U. S. 709, 722 (2012)

> (plurality opinion). This Court's precedents do not permit governments to impose content-based restrictions on speech without "'persuasive evidence . . . of a long (if heretofore unrecognized) tradition'" to that effect. *Ibid.* (quoting *Brown* v. *Entertainment Merchants Assn.*, 564 U. S. 786, 792 (2011)).
>
> This Court's precedents do not recognize such a tradition for a category called "professional speech." This Court has afforded less protection for professional speech in two circumstances—neither of which turned on the fact that professionals were speaking.

138 S.Ct. at 2371-2372.

> Moreover, this Court has stressed the danger of content-based regulations "in the fields of medicine and public health, where information can save lives." *Sorrell*, *supra*, at 566.
>
> The dangers associated with content-based regulations of speech are also present in the context of professional speech. As with other kinds of speech, regulating the content of professionals 'speech "pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information." *Turner Broadcasting,* 512 U. S., at 641. Take medicine, for example. "Doctors help patients make deeply personal decisions, and their candor is crucial." *Wollschlaeger* v. *Governor of Florida*, 848 F. 3d 1293, 1328 (CA11 2017) (en banc) (W. Pryor, J. concurring).
>
> Further, when the government polices the content of professional speech, it can fail to "'preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.'" *McCullen* v. *Coakley*, 573 U. S. ___, ___–___ (2014) (slip op., at 8–9). In sum, neither California nor the Ninth Circuit has identified a persuasive reason for treating professional speech as a unique category that is exempt from ordinary First Amendment principles.

138 S.Ct. at 2374.

In addition, Justice Anthony Kennedy wrote a concurring opinion, joined by Justices Samuel Alito and Neil Gorsuch and Chief Justice John Roberts in which he emphasized the dangers posed by legislation such as the FACT Act and "conversion therapy" bans, which are targeted at particular types of speech:

> [**I]it is not forward thinking to force individuals to "be an instrument for fostering public adherence to an ideological point of view [they] fin[d] unacceptable."** *Wooley v. Maynard*, 430 U.S.

> 705, 715, 97 S.Ct. 1428, 51 L.Ed.2d 752 (1977). It is forward thinking to begin by reading the First Amendment as ratified in 1791; to understand the history of authoritarian government as the Founders then knew it; to confirm that history since then shows how relentless authoritarian regimes are in their attempts to stifle free speech; and to carry those lessons onward as we seek to preserve and teach the necessity of freedom of speech for the generations to come. Governments must not be allowed to force persons to express a message contrary to their deepest convictions. Freedom of speech secures freedom of thought and belief. This law imperils those liberties.

138 S.Ct. at 2379 (Kennedy, J., concurring) (emphasis added).

The language in bold above is particularly relevant to the APA's proposed resolutions, which seek to force APA members and others to be instruments for fostering adherence to an ideological point of view. The content of the statements and authorities cited in the GICE and SOCE proposed resolutions attest to the organization's adoption of and reliance on an ideological point of view rather than objective scientific evidence. *See e.g.,* reference to https://www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy, a resource maintain by the Human Rights Campaign, which is a pro-LGBT lobbying organization, not an objective scientific source.

Similarly, the APA statements on GICE and SOCE cite the Movement Advancement Project: http://www.lgbtmap.org/equality-maps/conversion_therapy, another pro-LGBT advocacy organization. The resolutions also cite GAYLESTA, an association of LGBT-affirming counselors which touts its opposition to "conversion therapy," https://gaylesta.org/conversion-therapy. Absent from the sources for the APA's resolutions are peer-reviewed studies showing the effectiveness of psychotherapy for clients who seek to reduce or diminish same-sex attractions or behaviors or discordant gender identities, or statements from organizations such as the Alliance for Therapeutic Choice and Scientific Integrity, which provide scientifically based resources for psychologists seeking to honor their clients 'rights of self-determination in the context of same-sex attractions or behaviors and sexual identity issues.

The APA's exclusive use of pro-LGBT advocacy resources and exclusion of objective scientific sources examining the effectiveness of psychotherapeutic techniques honoring clients 'choices of seeking to reduce or eliminate unwanted same-sex attractions or behaviors and sexual identity issues speaks to the resolutions being ideological proclamations rather than evidence-based scientific guidelines. The APA's significant involvement in the accreditation of programs of study and approval of licensing standards by states and state educational institutions vests APA's adoption of an ideological or political position with significant consequences, far beyond than mere statements by a professional organization.

The United States Supreme Court has long established that the U.S. Constitution constrains "state actors" from infringing

upon citizens 'constitutional rights. *U.S. v. Stanley*, 109 U.S. 3, 26 (1883). The Court has determined that "state actors" are not merely governmental agencies and employees, but also, in certain circumstances, private organizations which perform governmental functions or are otherwise connected with the government when performing a certain action. *Shelly v. Kraemer,* 334 U.S. 1 (1948). Of particular relevance to the APA is *Brentwood Academy v. Tennessee Secondary School Athletic Association*, 531 U.S. 288, 290-92 (2001), in which the U.S. Supreme Court decided that the Tennessee Secondary School Athletic Association ("TSSAA"), a nonprofit, membership-based interscholastic association that regulated sports among its members, could be considered a state actor for First Amendment purposes. The Court held: "The nominally private character of the Association is overborne by the pervasive entwinement of public institutions and public officials in its composition and workings, and there is no substantial reason to claim unfairness in applying constitutional standards to it." *Id.* at 295. Similarly, while the APA is a private membership-based association, its substantial involvement in accrediting programs of study that lead to the licensing of professional psychologists could override its "private actor" label." That being the case, the adoption of these ideological regulations that mirror the constitutionally defective counseling bans in *Pickup* and *King* could subject the APA to liability for violating the constitutional rights of psychology students who cannot obtain a license unless they adhere to APA's pro-LGBT advocacy regulations.

Furthermore, such regulations could expose public universities and state licensing bodies to challenges from students and licensure candidates subjected to disciplinary action or denial of licensure if they do not adhere to the APA regulations. Universities and licensing boards would be placed in the position of having to affirm regulations that violate constitutional protections, placing them in a "Catch-22" situation. Faced with such a dilemma, universities and licensing board might seek other arrangements for accreditation.

The APA should seriously reconsider adopting these ideologically-based regulations that contradict core APA principles regarding client self-determination, invade the realm of religious freedom and subject its university and state licensure partners, as well as itself, to legal challenges based upon violation of constitutional rights.

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Navigating the Mob Mentality of Trans Activism: An Interview with Shannae Anderson, Ph.D.

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In this interview, Christopher Rosik invites psychologist Shannae Anderson, Ph.D., to reflect upon her experiences of being targeted by transgender activists following her testimony before a school board in California on behalf of parents who were facing child abuse charges for not calling their child by his new preferred pronouns. Dr. Anderson shares what she learned from her ordeal, the role of her faith, and some guidance for others who want to promote the welfare of children in this area.

Keywords: Transgender, activism, Christian faith, conflict

CR: Welcome, Dr. Anderson. Before we get into your sudden and unexpected rise to national prominence, could you tell our readers a bit about your personal and professional history?

SA: Hi there! Well, to begin, I don't think I have had a rise to national prominence! I am just a normal Christian, mother, grandmother, and psychologist who happened to speak out against evil and got viciously attacked for it. My story is more about how God can use someone for His glory!

I am a born and bred Southern California girl. I was raised in Thousand Oaks and attended USC for all of my degrees. I graduated with my doctorate in 1995 and started my professional career working in the chemical dependency treatment field.

Christopher H. Rosik, Ph.D., is a psychologist in Fresno, California, and past President and Chair of the Research Division of the Alliance for Therapeutic Choice and Scientific Integrity. He has published more than 60 articles in peer-reviewed journals and has made presentations across America and Europe.

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For several years and before he passed away, my first husband and I ran one of the top residential drug and alcohol treatment centers in the country called Anacapa by the Sea - STEPS in Port Hueneme. I have directed and consulted with a number of treatment programs and am currently the Clinical Director of Monarch Recovery Intensive Outpatient Program in Ventura. I taught at California Lutheran University in the Master of Psychology program, and for over a decade at Fuller Theological Seminary in their Recovery Ministry Program in the School of Theology. I have maintained a private practice for close to 25 years. I am currently living in Lynchburg, Virginia, working at the American Association of Christian Counselors (AACC) as the Director of Psychology and the Co-Director of Ethics and Advocacy and Adjunct Faculty at Liberty University in their Doctor of Psychology program.

I have been married to my current husband for 15 years and have a son who is deployed with the army in Eastern Europe. He is stationed in Texas with his beautiful wife and my precious granddaughter.

CR: How did you become interested in being a psychologist? What are your particular specialties?

SA: I actually never wanted to be a psychologist. I was pre-med during my undergraduate years at USC with a major in Exercise Science. My plan was to go to medical school and become an orthopedic surgeon. After my college fund was stolen (long story), I was forced to defer paying tuition for a semester which delayed my ability to immediately apply to medical school after graduation. During that interim summer, while working part-time at USC, my boss offered me a position on campus that would provide full tuition for graduate school. At that time, only a few graduate programs were still accepting applications for admissions and psychology was one of them. I quickly filled out an application (not knowing the difference between a master's or Ph.D. degree!), took the GRE, and about a month later I was accepted into the Doctoral program in Counseling Psychology and was granted the graduate assistantship to finance it all! I was initially only going to stay a year, but I found the discipline to be a natural fit. I was fortunate to be mentored by trauma expert John Briere and then I studied under Dan Siegel, the founder of interpersonal neurobiology, for seven years. My dissertation looked at how attachment mediates the long-term consequences of childhood trauma. Most of my work has been in trauma and the sequelae of such experiences. In my private practice I specialize in complex trauma, addictions, eating disorders, borderline personality disorder, and self-harm.

CR: I read that you, by nature, are not a fighter, and you professed absolutely zero interest in contending so publicly for the freedom of counselors to provide and people to receive therapy that explores their potential for sexual attraction and gender change. Could you share what changed for you that last year?

SA: Yes, until just over a decade ago, I had no interest in politics or current events despite my husband working for the Alliance Defending Freedom at the time. The game changer for me was when my husband and I began attending the church Calvary Chapel – Godspeak, pastored by Rob McCoy. Rob is known as the "Patriot Pastor," and he works with Charlie Kirk at Turning Point Faith. He taught our congregation the importance of getting involved in our community and being a voice for our faith and values. The first time I spoke out was during the COVID-19 lockdowns in April 2020. Pastor Rob started a nightly "fireside chat" on YouTube discussing the issues with the virus and the

mandates, and he asked me to speak and address the mental health consequences of the lockdowns. I became a regular guest on his show and started speaking at Re-Open California rallies and other events across the state. I also worked with attorneys from Advocates of Faith & Freedom in the fight to reopen churches and schools during this time.

I had no idea that entering this realm would bring on such profound vitriol. I was shadow-banned, censored, suspended, and canceled on social media. I had a long-term patient terminate her counseling with me after seeing my name listed as a speaker at a freedom rally. I was contacted and interviewed by the FBI after being placed on a targeted list by ANTIFA and was a victim of death threats. As the months turned into years of speaking and fighting this battle, I was recruited at the beginning of last year to address other issues within our community, especially the transgender indoctrination in schools. I was hired as an expert witness to testify on behalf of local parents who were facing child abuse charges for not calling their child by his new preferred pronouns (which I hear is now proposed to be a new law in California!).

I was then asked to speak at our local school board meeting after an incident where a third-grade teacher showed her students a transgender video without parental knowledge or permission. After speaking to the board, I was booed and hissed and accused of being a "hater" and transphobic by several in attendance. In response to my statements, a local transgender activist associated with the school board filed a complaint against my license. She claimed I violated my professional ethical standards and code of conduct, and because of me, there was an "imminent risk of substantial harm to students and families within the school district, all residents of the city and county." She claimed that I made statements about transgender people that "reinforce bigotry, exclusion and harmful acts" and that I was attempting to "restrict the civil rights of others." She labeled me a "white supremacist" and alleged that my conduct was "tantamount to an incitement of violence" as therapy with me would "put a patient at risk of great harm, including death." In addition to submitting her complaint to the board, she sent a copy of the 51-page document to my United States Congresswoman, my California State Assemblywoman, the City Attorney, the School Board Superintendent, and the entire City Council. This was all done to intimidate and silence me. It almost did.

By much prayer and God's grace and strength, I returned the following week to confront the board on endorsing this activist and to reiterate my position supporting the children. This meeting had over 500 individuals in attendance, including protestors and ANTIFA members. After confronting the board on their intimidation tactics, the threat against me was so great that five security guards were summoned to escort me out of the building and through the parking lot. Several individuals followed us and physically threatened us before we were able to escape. Since then, I have received communications from pseudo-potential patients requesting counseling appointments, to then set me up for not using "gender affirmation therapy." By God's grace, this ultimately led to a new job opportunity in Virginia to help lead the battle for religious freedom for Christian counselors.

CR: How vicious were the attacks on you after your school board testimony? How do you as a psychologist explain this vitriol?

SA: I was both shocked and horrified by the reactions I received. As a Christian, I believe those endorsing and supporting

these ungodly lifestyles are operating under a demonic influence that puts self and lusts and desires first. When you confront a demonic spirit, you get rage and hatred. As a psychologist, I believe this movement to accept and affirm any sexual deviancy has become cult-like, where you cannot question any of the tenets or you are attacked. Sadly, I think our profession has been undermined by "woke" activists starting in the academy and supported by left-leaning lobbyists who drive their extreme agenda. They seek to make themselves into their god as opposed to honoring the Almighty God and recognizing we all are created in God's image. They are driven by feelings and not facts, so when you present another viewpoint that is contrary to theirs, they "go limbic" and take their fury out on you.

CR: How hard was all this on your husband and children?

SA: My husband and son are in total agreement with my stance. In fact, they are more vocal than I. My son endured significant harassment from a professor in college (a "Christian" college by the way) when he shared there were only two genders. We all were a bit stunned, however, when the Southern California ANTIFA group tweeted a warning of my relocation to the Virginia ANTIFA! We had hoped the attacks would end in California.

CR: What are your biggest concerns about so-called gender-affirming care?

SA: There are so many! One of my biggest concerns is the quick affirmation and implementation of physical modifications in children and teens who do not have the brain capacity to make informed decisions. These choices will affect them for a lifetime. I fear, for example, the attempts in California to remove children from their parents to allow gender-altering treatments without parental permission. I also am so concerned about the parents who are often creating and promoting this phenomenon in their children. For example, according to one study, 53% of mothers of boys with gender identity issues suffer with depression and/or borderline personality disorder (Marantz & Coates, 1991). I have seen mothers obviously struggling with their own issues whom I believe are fostering and advocating for these changes in their children. Lastly, I fear that this is all a push to normalize pedophilia as another sexual orientation. We know the UN has endorsed sex with children for "Minor Attracted Persons." Our country is becoming more and more depraved.

CR: How do you explain the explosion of transgender and non-binary youth and young adults in the last decade? Is it mostly a social contagion or are there additional factors as well?

SA: I believe much of what we are seeing is a function of pulling God out of the schools and out of the culture which promotes a "self" driven life without boundaries or morals. Furthermore, the advent of social media has altered our perspective of what is "normal" and cool, so teens in particular need to push the boundaries to get even a small bit of attention and affirmation from their peers. As researcher Dr. Lisa Littman describes, there is an outbreak of Rapid Onset Gender Identity Disorder that has overcome our children, not unlike cutting and eating disorders in the past. But it's not just the explosion of transgender and non-binary issues, but the endorsement and celebration of severe mental health disorders as well. The youth of today are feeling lonely and disconnected and are seeking connection and an identity. Sadly, we are pushing their immature brains into embracing lies that have long-term devastating consequences.

CR: You are one of those small minority of Christian professionals who have had the courage to go public with gender truth that generates pushback from many who

find your position to be hate speech. How were you able to find that courage, and what have been the major benefits from going public with your views?

SA: Honestly, my courage and boldness come from God alone. I was the kid in school who would take the fail on an assignment over public speaking. But the Lord has matured me into recognizing my fear of man was an idol. I truly believe if we take seriously Psalm 56:11, "I trust in God, so why should I be afraid? What can man do to me?", He will give us the strength and courage to fight whatever battles may come our way. I have actually been surprised that God has grown and developed me into someone who isn't afraid to speak up against injustices. As a child I was verbally and physically abused for voicing my opinions, thoughts, and feelings, so to push through that fear of retaliation and actually feel empowered has been a great point of personal growth for me.

CR: We know that much of Europe is beginning to question the wisdom of and lack of science behind so-called "gender-affirming care" for minors. Meanwhile, it seems this movement is going full steam ahead in North America. Do you have any thoughts on what is going to happen in the future for such "gender-affirming care"? What do you think it will take to restore some sanity to our society and our mental health associations?

SA: I really hope our country wakes up and learns from Europe and chooses to actually "follow the science" which refutes the benefits of cross-sex hormones and transgender surgery to alleviate psychological distress. I think the recent boycotts of Budweiser and Target have demonstrated that the people don't want this transgender influence upon our kids in particular. I think what will hopefully turn this around will be malpractice lawsuits brought upon the mental health professionals who endorse and prescribe these barbaric actions and the surgeons who perform them. A colleague of mine recently attended a workshop on how to write one of these prescriptive letters and he was horrified at the simplistic and routine manner recommended to clinicians. He noted they discouraged any formal assessment, evaluation, or follow-up, and the patient didn't even have to be in treatment with the mental health professional. I also noticed the other day that to get a prescription for an emotional support animal, an individual must be in psychotherapy for a minimum of 30 days, yet a child can get a prescription for life-altering medications and surgery after a single brief meeting with a clinician. I am watching with great interest the two lawsuits filed by de-transitioners against the clinicians, surgeons, and clinics for medical negligence here in the US.

CR: Do you have any guidance you can give to parents of adolescent children who are telling them they are transgender or non-binary? Any advice for parents whose adult children have transitioned socially and/or medically?

SA: This is NOT my clinical area of expertise, but from what I have read, the research shows that 80% to 95% of children and teens who struggle with gender identity issues mature out of it if they are not exposed to social affirmation and medical intervention. As a result, a "watch and wait" method is best. I also recently read that gender identity issues should be identified as a part of normal adolescent development, where teens try on different identities to see what fits. I know in my practice, several of my teen patients who presented with sexual and gender identity issues grew out of those issues and by young adulthood were in traditional heterosexual relationships and identifying as their God-given gender.

CR: What guidance would you give to therapists and pastors who are concerned but perhaps afraid to speak publicly about this issue?

SA: It is natural and normal to feel afraid, but the Lord has not given us a spirit of fear! I believe that we as believers are to be the moral compass for our culture. When we are silent, we are tacitly (using their word) "affirming" their stance and actions. As Dietrich Bonhoeffer said, "Silence in the face of evil, is evil itself" and "Not to speak is to speak. Not to act is to act." If we are silent, if we do not act against the evil being perpetrated against our children, we are complicit. I recently became a grandmother and am just so in love with this bundle of joy. But I am terrified for the world in which she will grow up! We all need to take action to stop what is happening in our world. You may not feel God calling you to be a leader in this battle, but anyone can write a letter or make a phone call to a school board superintendent or state senator.

CR: Can you tell our readers how your faith has informed and guided you through the events of the past year or two?

SA: As I have mentioned, this is all about my faith in God. Going back to when I was young, I have always sought to follow God's will. He led me into this profession and it's up to Him how He uses me. It is really none of my business. I am sold out to Jesus and just want to be obedient to His call. It has been challenging and scary at times, but ultimately at the end of the day, I love what Pastor Rob says...they are threatening me with heaven!

CR: I know a lot has changed for you professionally since all this took place. Could you update readers on your current and future professional pursuits?

SA: As I mentioned, I moved to Virginia about nine months ago and am on the frontlines fighting for religious freedom for Christian counselors. The liberal progressives in the field do not believe that we as Christians should even be in this profession, given our moral principles. Our profession of Christian counseling is facing an existential threat that many have no clue about! Christian graduate programs are being threatened with losing their accreditation if they don't comply with the latest requirements that align with the LGBTQ+ doctrine. Continuing education courses that teach faith-based interventions are having their approval revoked. Therapists nationwide are being brought before their licensing boards for following their conscience and faith-based treatments that may disagree with the liberal agenda. We are in a battle in which we need to engage and fight! In my position at AACC, we are supporting Christian counselors in maintaining their religious freedom and rights of working according to their conscience.

CR: Thank you so much for sharing your thoughts and experiences. Any final comments or encouragements for our readers?

SA: Thank you for granting me the honor to share my story. I hope it gives hope and encouragement to others that they don't need to sit by and watch the destruction of our values, our profession, and our country. They can take action as well.

Lastly, I want to share that despite the ordeal I have gone through, the Lord has protected me. It has been exactly one year ago from when I received notice of the complaint against my license, and I have never heard anything from the board. I don't know if they are investigating or if they have reviewed it and found it to be nonsense, but God has protected me from the fiery darts of the enemy for His glory! Amen!

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The Integrity of Christian Sexuality

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The Christian understanding of sexuality is securely rooted in general and special revelation, allowing us to reason with believers and nonbelievers alike, offering a paradigm that is comprehensive, spans time and culture, and honors the dignity of the individuals and groups we encounter in human services. This article will illustrate how our sexuality reveals profound truths about God's nature and his plan for humans. The article explores the roots of our emerging sexual identity crisis in society, and how the Christian vision speaks to the Gospel itself. We will see how honoring God's intent does the greatest good for human flourishing, protecting from trauma and healing sexual and gender-based wounds. With a sound biblical anthropology echoed in Theology of the Body and affirmed by Natural Law, we can address issues regarding sexuality in a manner that is compassionate and comports to our convictions about truth.

Keywords: *sexuality, gender, identity, Theology of the Body, natural law*

The contemporary church, particularly in the West, has been caught unawares in many respects by the progressing evolution of the modern-day Sexual Revolution, made most evident in the activism of the LGBTQ movement. Christians involved in the public square, especially in human services, face the demand to acquiesce to pressures to conform to the latest iteration of sexual orthodoxy. To stand in contradiction to such disagreeableness not commonly found in the constitution of

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individuals drawn toward the helping professions. Unswervingly, our institutions work to ingrain in the students and professionals the belief that continued access to the field of human services is contingent on affirmation of all sexual and gender identities professed by the individuals we serve and with whom we associate. We are told that we are unenlightened, bigoted, and causing supreme levels of harm if we object or explore alternatives with our clients.

Within our own communities as Christians, we are fractured. The conservative or traditional Christians preach adherence to biblically based doctrines accepted by ecclesiological consensus over the past two millennia (not to mention the foundational sexual ethics of Judaism). Their concern is for the integrity of authentic Christianity, and their heart is to include the lost world through repentance and discipleship. The concern of the more liberal among our ranks is to provide for the needs and longings of individuals and groups that fall outside the norms of biology, societal standards, cultural stereotypes, and even biblical truths and commandments. This subset of professing Christians is split between those who support LGBTQ activism because of personal agreement with pro-LGBTQ revisionist theology or philosophy and those who may doctrinally disagree but believe the compassionate heart of Christ is best reflected by affirming the sexual and gender identities every person sincerely claims and perhaps even combating potential discrimination against LGBTQ inclusion. Therefore, the tension within the church is easily conceived (however, to some degree improperly) as a conflict of the soft virtues of love, mercy, and empathy versus the hard virtues of integrity, righteousness, and rationality.

When faced with the public institutional compulsion to affirm and accommodate LGBTQ identities, sexual relationships, and family structures, even to the point of restricting research and therapeutic options for questioners and dissidents of the new sexual orthodoxy, Christians on either end of the conservative-liberal spectrum respond with compartmentalization. Our secular society has conditioned us to assume that the realm of morality is private, subjective, and ought to be excluded from the realm of objectivity with its shared understanding of reality and policy. Even conservative Christians are often intimidated out of the conversation, convinced that the application of their own worldview upon non-adherents would be unjust and potentially oppressive. Therefore, the current conservative position has been reduced to a form of libertarianism, with the sole request of being free to live independently. This leaves Christians believing they have little to offer the non-believing world regarding the crisis of sexual identity in which we now find ourselves.

I propose we rediscover and boldly proclaim the authentically Christian understanding of sexual and gender identity. We will find that a biblically faithful view is not in conflict with the best scientific research nor with the virtues for which both ends of the Christian spectrum advocate. We need not be ashamed or uncertain of the church's position and approach to both our own members and to the non-Christian world. We can be confident that Christianity offers a paradigm of understanding human nature and sexuality that is comprehensive, transcends time and cultures, and that honors the dignity of the individuals and groups we encounter.

The Christian understanding of sexuality is securely rooted in general and special

revelation, allowing us to reason with believers and nonbelievers alike. Simultaneously, the Christian worldview is beyond the stereotypes and biases of culture; therefore, if one must stand in opposition to any idea in the world or church, one can do so with integrity. It is imperative that we are confident that truth and compassion are not mutually exclusive. Rather, the truth is our pathway to the restoration and redemption of our broken humanity.

Theology of the Body

The biblical, historic vision of sexuality is beautiful, enticing, dignifying, and redemptive. When one adequately grasps it, one is gifted with a sure foundation for navigating the chaos of our fallen world as well as a compassionate heart to be a vessel of God's love. Indeed, understanding our sexuality is critical to understanding the Gospel itself.

As Christians, our entire belief system derives from God's Word, his self-revelation given to us. To be precise, his Word takes three forms. Creation came about by God's spoken word, the divine Logos, the logic by which God purposefully created the world. We have the inspired words of Scripture, transmitted by the Holy Spirit through human authors over centuries, further unveiling his nature and plan. And the fullness of God's self-revelation and self-giving is the incarnation, Jesus Christ, the Word made flesh. Taken together, we have the full truth about God's design, desire, and destiny for humanity, and hence our sexuality.

As a man who wrestled with sexual sin and then a counselor who works with people struggling with aspects of sexuality, I have been contemplating the meaning of sex, gender, desire, identity, and marriage for years. I owe an immense debt to the ministers and scholars who have gone before me, and I am especially grateful to Christopher West, through whom I was introduced to Pope John Paul II's Theology of the Body (Restored Hope Network, 2015). Unbeknownst to a lifelong Protestant like myself, John Paul II's life mission was to prepare the church for the Sexual Revolution by offering a deep philosophical and biblical study on personhood, love, sex, and marriage. For decades, he formulated his theology, and when he became pope in late 1978, he set out to deliver his teaching in weekly talks from 1979 through 1984, which were subsequently compiled into the book, *Man and Woman He Created Them: A Theology of the Body* (2006, originally published 1986). I have found this teaching to be compatible with the other traditions in Christianity, as it is thoroughly rooted in both Scripture and the church's historic doctrine, and I have been happy to see a growing number of Evangelical teachers and authors reference this comprehensive work with appreciation or arrive at similar conclusions in their own independent study (Byrd, 2022; Crabb, 2013; Pearcey, 2018; Roys, 2017; Tennent, 2021). If the church is to respond with relevant (to use a word I despise) answers to people in crisis, we need an adequate and robust theology of sex.

We must start with an adequate anthropology, an understanding of what it means to be fully human. When Jesus was questioned about a contemporary debate in his community about marriage (and hence, sexuality), he answered by pointing back to Genesis and God's original design and intent for male and female (Matt. 19:1-6). Scripture declares that God uniquely created humans—both male and female—in his image and likeness, with the authority and responsibility to govern the created world (Gen. 1:26-28). The doctrine

of the Imago Dei (image of God) has multiple implications.

First, it shows us something about the nature of a human being. God designed the first man out of the material of the earth, then gave him life by breathing his Spirit into him. Therefore, human nature is neither purely physical (as we understand the animals) nor purely spiritual (like the angels), but a body-spirit composite, a marriage of the physical and spiritual. We tend to think that we are spirits trapped inside bodies. But as we will investigate more in-depth later, this notion is a vestige of Gnostic dualism that has crept into Christianity. The authentic Christian understanding of human nature is incarnational and holistic (West, 2020, p. 7). In our secularized society, we can fall into thinking that materialist philosophy, because it claims that matter is all that is real, places a high value on the physical world. But the truth is that materialism reduces the body to physical elements and processes devoid of higher meaning (Pearcey, 2018, p. 24). It is Christianity that elevates the body, recognizing its inherent significance.

The Imago Dei is our basis for universal human dignity. Let us consider the context of this passage. Genesis was recorded after the Israelites had just escaped 400 years of slavery. The idea of a human being made in the image of a deity was not a novel concept, but up to this point, the title was applied only to royalty. To learn that the image of God starts with the father of all humanity and, therefore, passes down to all generations, which was reinforced in the Noahic Covenant (Gen. 9:6), was a revolutionary thought for those who had been conditioned to view themselves as inferior and oppressed victims.

Even more so, the Scripture declares that male and female are equal in bearing the image of God. From our modern standpoint, we often take for granted the equal value of all persons. The ancient world did not have such an assumption (and many societies across the globe that lack a Christian influence in their heritage still do not). There were no special provisions or protections for women (or children). However, throughout the books of the Law, we observe God dictating regulations that elevated the status of women in ways the surrounding nations would not even consider. In a world in which the most powerful men could express their sexuality upon as many individuals (women or otherwise) as they pleased, God's creation and enforcement of the institute of marriage as the only ordained context for sexual expression constrained sexual behavior to a relationship that honored the dignity of the other person. This was the first Sexual Revolution. The normalization of this standard spread across the civilized world as the Gospel progressed throughout the Roman Empire. The sexual ethics that distinguished the Israelites from their Canaanite neighbors were now replicated on a global scale under Christendom.

Beyond the equal worth of male and female, the Imago Dei provides deeper mysteries. When we read that we are made in God's image, because we also know that God is spirit, we tend to restrict the meaning of Imago Dei to the fact that humans possess certain immaterial qualities, such as an immortal spirit and conscience. These are certainly correct, but we tend to miss how our bodies themselves are reflections of God's own nature. John Paul II's primary thesis in Theology of the Body is "The body, in fact, and only the body, is capable of making visible what is invisible: the spiritual and divine. It has been created to transfer into the visible reality of the world the mystery hidden in eternity in God, and thus to be a sign of it"

(2006, p. 203 {19:4}). In this manner, the body is not only biological, but it is theological. This elevation of the body does not mean that Christianity favors modernist materialism over postmodernism. Because God is spirit, the immaterial is indeed ontologically higher than the material. But the entire physical world, especially in our sexuality and marriage, is sacramental—physical signs of greater spiritual realities. This is how the premodern world understood the natural order and spiritual (and moral) order to be integrated. Through symbols, phenomena we take for granted unveil mysteries of how reality works. As a consequence of the Enlightenment's split between the physical and spiritual, society and even the church have lost their awareness of symbolism. We have lost our ability to read the sign language of our bodies. We must recapture this sacramental, symbolic framework if we are to detect the truths God is communicating through our sexuality.

Humanity's creation into two sexes is intrinsic to our being made in God's image. The wording of Genesis 1:27 is not coincidental. "So God made man in his own image, in the image of God he created him; male and female he created them." Adam, in his original solitude, was incomplete. God could have chosen to design Adam to reproduce asexually. But God formed out of man his counterpart and officiated the first marriage, calling the two to reunite as a one-flesh union, because this sexual difference reflects something about God. The individual sexual systems of the male and female bodies are incomplete and unfulfilled in their purposes alone. The instinctive longing for complementary union points us toward God's own relational nature. Through the whole counsel of Scripture, we know that God is a Trinity composed of distinct persons in a community of giving and receiving love. Linda Seiler (Restored Hope Network, 2016) notes that the Shema prayer in Deuteronomy 6:4 reveals that God (using the plural Hebrew word *Elohim*) is one in essence or a compound unity (the Hebrew word *echad*), and this same word for "one" is used in Genesis 2:24 when it says a man shall unite to his wife and they shall become *one* flesh. From certain traits about God—his creativity, relational self-giving, and unity in diversity—we can deduce ways in which he designed humans to image him. We are to unite in marriage with a partner who is similar in humanity and maturity but opposite in sex, forming a relationship of self-giving for the good of the other, open to the creation and development of new life.

Not only does the sexual difference in humans reflect the loving community of the Trinity, but it also serves as a prophetic sign of God's plan for us to participate in the community of the Trinity as the future Bride of Christ. An expansive view of the narrative of Scripture reveals God's desire for us to unite not just as man and woman in earthly marriage, but for us to unite with him in a heavenly marriage, thereby uniting heaven and earth. The Bible begins with the first marriage. Throughout the story of Israel, we see God refer to Israel as his wife, to whom he is faithful despite her adultery. Centered in the Bible is a celebration of our union with God in the erotic poetry of Song of Songs. Jesus arrives as the Bridegroom, performing his first miracle at a wedding, offering his self-gift to the Samaritan woman at the well, using a wedding as an image of the Kingdom, and promising to prepare a place for his Bride. In Revelation, we see our ultimate destiny in the wedding feast of the Lamb. Paul alludes to this spousal analogy in Ephesians 5:22-33, connecting the marriage in Genesis to the marriage in Revelation. As Christopher West exclaims

(Restored Hope Network, 2015), God wanted his marital plan to be so plain to us that he stamped an image of it right onto our bodies. And he designed our maleness and femaleness to communicate ultimate meaning! This is how understanding our sexuality prepares us to understand the Gospel.

All of this bestows profound dignity and honor upon each person, and both sexes image this story in specific and glorious ways. The very words used for male and female in Hebrew carry this meaning. The Hebrew for male is *zakar*, which has two meanings. The roots of the word mean "sharp, pointed," a clear reference to the protrusion of male anatomy (Hicks, 1993, p. 48). The other meaning of *zakar* is "to remember, to make an impact." Taken together, the male images God's masculinity in his initiation of a self-gift (Crabb, 2013, pp. 67-68). He remembers God's story of creation, taking action and continuing it, by moving to impart the seed to conceive new life. For this reason, God presents himself as masculine (Father, Son, Husband) in his special revelation to humanity—not because of the male bias of the biblical authors, but because God is always the one that initiates relational union with us and offers us the gift of eternal life by giving of his body and identity.

But this offer of self-gift must be received willfully. So, in contrast to the pointedness of *zakar*, the Hebrew word for female is *neqevah* (or also spelled phonetically *neqebah*), which means "pierced, bored through, opened to receive," referring to the female's internalized reproductive system (Crabb, 2013; Hicks, 1993). Feminine receptivity is not mere passivity; it is volitional, responsive, and invitational, bringing about a reciprocal gift of self. Mary, the mother of Jesus, images this so well, as she agrees to the proposal to conceive the Messiah. In her posture of openness to God's self-gift she became a model of the universal church, showing that in relation to God, men and women alike are feminine. As Ephesians 5 makes clear, the husband is symbolic of Christ while the wife is symbolic of the whole church. When we understand God's plan of salvation to be about union, we see how the marriage of man and woman is a model of Heaven uniting with Earth. This symbol stretches back to the beginning. Parallel to God speaking the Logos into the void of chaos, thus creating the habitable earth and humans to whom he imparts his identity, so the male enters the undifferentiated potential within the woman and imparts, by his seed, identity to the consequent new life. And just as the woman's womb is the ideal protective environment to grow and nurture new life, so the church is designed to conceive, protect, and develop regenerated lives, edifying them with the spiritual gifts in the Body.

First John 4:8 declares that God is love. And we most image our Creator in our call to be gifts of love, the subject of Karol Wojtyla's (later Pope John Paul II) earlier work, *Love and Responsibility* (1981). The word "person" was coined to mean more than an individual specimen of the human species, as if we were one of the animals. Rather, personhood indicates we are beings with rich, rational inner lives, focused on the pursuit of truth, goodness, and beauty. In our interpersonal interactions, we can approach the other person to love or to use the other person. To use is to treat the person as a means to an end that serves oneself but not the other person, such as the gratification of mere sexual pleasure or solving a narcissistic wound. But to love is for two persons to form a bond in pursuit of a willfully chosen, mutually desired end. And to protect this relationship from devolving into one of use, the end is an

objective common good.

Regarding marriage, the goods are procreation, generation of a family, and the continual ripening of the marital bond. That which God desires for us is for our own good as well as his—for he delights in his Bride. He is not tyrannical or exclusively self-serving. Ultimately, to love is to desire and act toward the good of the other person for the sake of the other person. In this way, each person becomes a gift of self; in fact, each human person is uniquely designed to be an indispensable, unrepeatable, irreplaceable gift. And the prerequisite of seeing oneself as such a gift is to adequately appreciate the goodness in oneself as a person and as a male or female, as well as seeing the other as good and trustworthy enough to risk the vulnerability inherent to love. In our now fallen world, our goodness is not so evident. But Jesus, who is wholly good, gave of himself fully in the most vulnerable way—wounded, rejected, and killed for our transgressions—to make us whole and holy.

As a guide to our destiny for ultimate union with him, God placed within us erotic desire. At its core, sexual desire is a reminiscing of what we lost in Eden and a longing for the future marriage with Christ. The bodily, sensual pleasures we experience in this life are designed to be foretastes of the ecstasy we will experience in our union with God. These pleasures point us toward our destiny in so far as they are fulfilled in this life in the manners that properly symbolize what is true, good, and beautiful about God's union with us. Our desires for union become dis-ordered when they are directed toward what is outside God's design.

In the original creation, the first man and woman experienced the goodness of their maleness and femaleness. And thus, they were naked and felt no shame, for at the core of shame is alienation. But in the beginning, we enjoyed four types of unities. Humanity was united with God. There was a union between body and spirit. Man and woman shared a common humanity and were united in the loving bond of marriage. And mankind was united with the rest of creation as the steward tasked with dominion and continuing God's creative acts. In each of these unions, there remains distinction. Man and woman are united but still different and not interchangeable. God and humanity were united originally and in our future destiny for those in Christ, but we never lose the Creator-creature distinction. In fact, it is the complementary difference that affords the union. There must be commonality in essence, but if there is too much sameness, there can be no union that produces life. The union of a human and God is spiritual life; the union of body and spirit is physical life; the union of man and woman creates new human life; and the proper harmonious relationship between mankind and nature produces an ecosystem that sustains life.

Once we grasp the ethos of our sexuality, the ethics of sexual morality make sense. God's laws are not arbitrary or oppressive. He delineates standards for sexual and romantic behaviors and relationships to protect the symbolic integrity of our sexuality so we can rightly discern his beautiful, life-giving nature and destiny for humanity. Because God is a creative, relational, paradoxical communion of different persons who are one in essence, and we are meant to image him, Linda Seiler (Restored Hope Network, 2016) shows how sexual sins undermine the integrity of the Imago Dei. Pornography, masturbation, and fornication lack the necessary relationship and commitment. Divorce breaks that commitment. In bestiality, there is too much difference for a true union. In homosexuality, there is too

much sameness for the necessary complementarity for union. Further, since a marital union is meant to image Christ's love for the church, we can derive a positive sexual morality from the free (not under compulsion), full (a total gift of self), faithful (exclusive and committed), and fruitful (oriented toward and open to procreation) love Jesus demonstrates. The Christian ethos is simple, clear, and grace-filled—an ideal built on truth from the integration of God's Word: nature, Scripture, and the incarnation (Doyle, 2018, p. 39).

Historical Attacks on Integrated Sexuality

Our adversary, Satan, hates humanity, envying our ability to image God bodily and create life. Therefore, where there is union, the enemy always seeks rupture because the result is always death. So, he deceived the first man and woman to commit the same prideful sin that separated him from God. In grasping for their own autonomy, Adam and Eve attempted to be more than creatures with the image of God, but to usurp him as the Creator and definer of their identities. The result of the Fall is the realization of the vulnerability of our own bodies and the commoditizing of others' bodies to be used, not loved. Instead of initiating connection for the good of the other, historical man has initiated in order to dominate. Historical woman has seen her openness to receive not as a gift, but as a vulnerability to be overcome. We tend to see ourselves and others not as persons whose rightful due is to be treated as objects of love, but as objects for use (Wojtyla, 1981, p. 42).

It is no wonder why, in such a world that falls short of imaging God's loving nature, individuals would fail to see or understand the beauty and goodness of their maleness or femaleness. The connection between our spirits and our bodies has been severed, the exact definition of death. On a society-wide scale, we cannot recognize our sexuality as a symbol of anything theological. Therefore, we reduce the meaning of sex to pleasure or some other utilitarian end (West, 2020, p. 20). Lost in our sin and the consequent brokenness, we are alienated from our Creator, the source of our true identity, and therefore, alienated from ourselves.

Satan's plan to rupture the original unities has progressed throughout history. If we are blinded to the meaning of our bodies, then we may yet remain alienated from God, or at least unable to perceive our true identities and not escape the corruption in the world caused by our evil, disordered desires, thereby making us unfruitful in our knowledge of Christ (2 Peter 1:1-11). The first major threat to the message of the Gospel was ancient Gnosticism. In general, the Gnostics preached a strict dualism, claiming that the physical world was created by an evil god, making all physical things innately corrupt or at least meaningless. Therefore, one's immaterial true self attains salvation by escaping from the physical world through gnosis, higher levels of enlightenment. The Gnostic influence infiltrated early Christianity with the heresy Manichaeism, which condemned the body and sexuality as wholly evil (West, 2020, p. 8). We see vestiges of this thinking in modern Christianity when we view ourselves as spirits trapped in bodies and we view spiritual life as something ethereal rather than incarnational. The true Christian vision is the redemption and resurrection of the body, not an escape from it.

With the advent of the Enlightenment, the proposition that only truths about the material world could be reliably known was promoted as the standard axiom of

modernity, as well as the core of what people mean when they now say they believe in science rather than religion. This cultural shift is what Pearcey (2018, p. 12) calls the facts/values split. This extreme form of dualism, characterized by René Descartes' dictum "I think, therefore I am," is actually a secular resurgence of the Gnostic mystery religions. Although the secular Enlightenment thinkers, on the surface, seemed to elevate the material world, they allowed for the immaterial to be known, but only in a private, subjective manner—much akin to gnosis (thereby unwittingly occasioning their own opposition in future postmodernism). While objective truths could reliably be known by reason and empiricism, subjective truths could be known only by the individual's intuitions or the preferences of the group to which the individual belongs. Nevertheless, the modernists asserted that knowledge of the material world is superior to knowledge of the immaterial, which includes values. This dualistic sentiment gives way to the is/ought split, the idea that we cannot arrive at a moral imperative (an "ought") from a description of physical reality (an "is").

Throughout history, there have been two general responses to Gnostic dualism: hedonism and stoicism. Divorced from the immaterial and spiritual, both approaches assume that the body has no intrinsic meaning or value. Therefore, the hedonist advocates the pursuit of physical pleasure and comfort, while the stoic denies physical desires to attain a strengthened state of detachment from the physical. In view of the dangers of sexual sin, Christianity has carried out this stoic approach in forms of puritanism, oftentimes rejecting the innate goodness of our sexuality or reducing its purpose to biological reproduction. Eventually, however, as Christopher West points out (Restored Hope Network, 2015), this "starvation diet" is insufficient and gives way to the "fast food diet" of indulging sexual desires impulsively or addictively. We can easily understand the 20th Century Sexual Revolution as a reaction to generations of puritanical repression born from Gnostic influences in the church and the society it produced, made worse by hypocritical allowances, male chauvinism, and the persecution of those who fall outside the sexual norms. This is the result of an Enlightenment project to establish sexual norms in a cold, rationalistic manner separated from a narrative and appreciation for the spiritual meaning of our sexuality. Reason may help us discover the true and good, but not necessarily the beautiful.

Enter philosopher Jean-Jacques Rousseau, the father of Romanticism and forefather of future Leftism. In James Lindsay's summation (Stuckey, 2022), Rousseau despised being reasonable. He posited that humans are restricted oppressively by societal expectations, so he envisioned transforming reality through social constructs in order to create an ideal society that facilitates the freedom of each person's true imaginative, instinctual nature. Add to that Sigmund Freud's insistence that the expression of one's sexual desires is essential to the fulfillment of the pleasure principle, and we have some of the major underpinnings of the LGBTQ+ identity revolution (Trueman, 2022, p. 72). In our postmodern frame, meaning is not derived from our bodies, but imposed on them as a social construction (Pearcey, 2018, p. 31).

The ensuing conflict between the Enlightenment and Romantic traditions progressed into the current battle between modernists and postmodernists. The question is what determines reality: the physical world or one's internal experience and perspective? And which approach will

be our basis for morality and social norms?

Secular modernism evolved into atheistic naturalism and Darwinism, with the assertion that the physical world is the product of impersonal, accidental forces and devoid of intrinsic meaning and value. This created the need for an immaterial explanation of human worth, resulting in the invention of personhood theory. The physical body is a fact reliably knowable through empiricism, whereas the person is immaterial and—because of the facts/values split—is the basis for rights. But how is the true person known? This body/person split left the field open for postmodernists to assert the increasing array of sexual identities based not on the objective facts of the body but on subjective experience. Combined with the Marxist-derived theory of oppression through the hegemony of normalcy, the postmodernists reject the notion that we ought to privilege objectivity over subjectivity in determining reality and morality. Therefore, the body is extrinsic to the person, inferior, and subject to pragmatic purposes (Pearcey, 2018, p. 21).

From their Gnostic perspective, the LGBTQ+ sexual revolutionaries posit that their true selves are oppressed by the restrictions of biology and the norms reinforced by society (particularly from its Christian heritage), providing them their opportunity to claim special protections and rights as sexual minorities, with their grander vision to deconstruct the traditional norms of society and religion and secure the freedom to reconstruct the self, marriage, family, community, and surrounding institutions. They accomplish their agenda by complicating (or "queering") concepts that society had taken for granted—sex, gender, love, marriage, family, etc.—so we lose our certainty over even objective reality and make us dependent on the enlightened elites (particularly those who have lived experiences of marginalization) for our new social constructions of reality (Stuckey, 2022).

In this view, every idiosyncratic sexual feeling, relational dynamic, and self-concept constitutes distinct sexual orientations and gender identities. Cognizant of it or not, LGBTQ proponents are operating under continuations of two-level dualism. The modernistic frame views sexuality as a product of materialistic forces, hence the insistence that homosexuality (in all its degrees and variations) is inborn and immutable. In contrast, the postmodern frame views gender as a product of social forces. And as postmodernism gains more power over modernism and Christianity, society lends credence to the idea that the authentic self is autonomous and free to impose its own interpretations on the body since the body is just raw material with no intrinsic identity or purpose. Queer theorists and LGBT activists believe they are obtaining justice for LGBTQ people who—by their very existence—are oppressed by normality (Pearcey, 2018, p. 160). Whereas in Christianity we know that freedom is found in living in harmony with the body, the world's goal is complete freedom to declare one's own identity and will not tolerate having options limited by anything one did not choose, even the body (Pearcey, 2018, p. 210-211). In this way, the LGBTQ movement is a clear extrapolation of humanity's first sin in Eden.

With this mission, they promote the advancement of changing gender/sex or synthesizing new sexual identities and families (through surrogacy and adoption) to validate their identities, while simultaneously opposing counseling efforts to help people align their identities, feelings, and behavior with the teleology of their bodies, calling such counseling

"conversion therapy." The LGBTQ advocacy group, The Trevor Project, which has immense influence on social media's community guidelines and public policy, defines "conversion therapy" as "any of several dangerous and discredited practices aimed at changing an individual's sexual orientation or gender identity" (n.d.). The APA Guidelines for Psychological Practice for Sexual Minority Persons (2021, p. 17) prefers the term SOCE (sexual orientation change efforts) over "conversion therapy" or "reparative therapy," but similarly defines SOCE as "attempts to modify sexual minority orientations" and repeatedly states that SOCE is proven to be harmful, citing the earlier 2009 Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation. However, the Task Force Report claims that there are no studies of sufficient rigor designed to assess the prevalence of harm or efficacy of contemporary forms of SOCE (pp. 42-43) and no empirical research on children and adolescents (pp. 72-73).

This "conversion therapy" accusation brings us to the question, "Is the sexual identity crisis a morality or mental health issue?" In the broadest sense, sin is "to fall off the right path" (Hebrew *hata*) or also "to miss the mark" (Greek *hamartia*). This general definition of sin includes unintentional deviations, conscious transgressions, and persistent rebellion against God's will. Sexual sin, therefore, is any way in which one's thoughts, feelings, desires, behaviors, and relationships miss the mark of God's design, desire, and destiny for our sexuality. With this definition in mind, some proclivities people may have that might be (or used to be) categorized as mental or behavioral disorders may reasonably be classified as sin without assigning intent to the individual. Whether we fail to meet God's normative standards because of the corruption of human nature through Original Sin, from certain wounds or losses, willful rebellion, or the influence of spiritual forces and the world, God's good standards remain.

But God's passionate and sacrificial love for us initiated his gift of salvation. He came, as a man—in a male human body—through a woman, to restore us to our original dignity and even elevate us higher in the future resurrection of our bodies. His incarnation and bodily resurrection and ascension affirm the goodness of our bodies and begin the process of redeeming them. Whereas the Enemy comes to steal, kill, and destroy (rob us of the integration of body and spirit, separate us from God, deconstruct our understanding of who we are, and destroy our relationships), Jesus came to make us fully alive (by restoring the integrity of our identities, reviving us, and rebuilding us and our relationships into his triune likeness).

Natural Law

Now, with that cursory survey of the rise and fall of our sexuality, how are we to understand sexual orientation and gender identity? And how are we to operate and communicate with a world that may not subscribe to the awe-inspiring vision for our sexuality that Christianity holds? We certainly must not stay silent, depriving people of the truth they desperately need. Simultaneously, we can be secure that there are levels of understanding that people may comprehend and by which they may participate even if they cannot articulate the propositions of Christianity. Truths must be lived out before they can be understood. In this regard, a social fabric that supports traditions and policies consistent with the natural order would go a long way in curtailing our sexual identity crisis.

Our most reliable basis for sexual orientation and gender identity is the design of the body. This is not because the physical is all that there is, nor even that it is all that matters—in fact, quite the opposite, the invisible is ontologically more real than the visible (2 Cor. 4:18). Rather, in the same way that the incarnated Son reveals the Father (John 14:6-9), so God designed our bodies to reveal the person. Our bodies tell us who we are. We cannot deconstruct and reconstruct a different reality in which gender and sexual orientation are incongruent with our bodily design (Nicolosi, 2009, p. 29). A society that denies the reality of our bodies and the reality toward which they point is a society with a sexual identity crisis.

Empirical observation of God's general revelation in creation can afford us abundant knowledge about the natural order. Our bodies are not arbitrary; they have a design and function that point toward a purpose—a telos. We know just through general revelation that humanity is bifurcated into two sexes and our sexuality is designed for the union of these two sexes for the outcome of procreation and the establishment of a pair-bond that can support each other, raise offspring, and be the basic unit of civilization. Humanity's collective, instinctive awareness of this natural order over generations produces Natural Law philosophy to protect us from veering from these purposes (Nicolosi, 2009, p. 29). Premodern people understood the difference between the physical and spiritual, but saw them as integrated in meaningful ways. The pre-Christian pagans were aware of the "law written on the heart" (Budziszewski, 1997, p. 181). Therefore, at a minimal level, we actually can arrive at moral imperatives (an "ought") from knowledge of nature (an "is") because we recognize the genuine good of the telos.

It is important to remember that teleology acknowledges a Creator. If we look at biological structures as accidents of mutation and blind processes, we will ultimately miss the embedded meaning in the order of nature and existence (Wojtyla, 1981, pp. 56-57). The atheistic naturalism of our era may attempt to deny it vehemently, but there is such genius and beauty imbued in the created world that it points all of humanity to an intentional Creator who transcends the physical world. And despite the infection of imperfections from the Fall, the creation will always exhibit the inherent meaning God placed in it. Those who deny the teleology found in general revelation are suppressing the truth and become futile and darkened—ironically, rather than enlightened—in their understanding (Rom. 1:18-23).

Before proceeding further, I must give a word about language. Likely due to our poor cultural memory and intellectual laziness, we have sacrificed much of the terminology over the past several years (and decades) of the Sexual Revolution. The current mantras are that sex, sexual orientation, and gender are all separate and even unrelated realities. But our words are honest only if they conform to reality.

Proper ontology and teleology are critical here. When people claim a sexual or gender identity divergent from the reality of the body, then there is a confusion of ontology, the understanding of *what* one is. A biblical, integrated view is decidedly essentialist, meaning that we understand every category of being has an essence, essential traits necessary to *be* that entity. When people desire and pursue sexual sin (homosexuality, for example), there is a confusion (or intentional denial) of teleology, the designed purpose of something. Integrated sexuality is a result of proper teleology based on proper ontology.

The Middle English word "sex" is a combination of the Old French *sexe* and the Latin *sexus* (the same root for "sect" and "section"), which means "division." Therefore, integral to being human is being a member of either of the two sexual divisions necessary for procreation. Adding prefixes to the word "sexual" actually confuses the meaning: heterosexual means "different difference," which is redundant; homosexual means "same difference," which is contradictory; and asexual refers to a species that reproduces without sex, which is certainly not true of humans (having low sexual interest does not negate the reality of one's sexed identity). In other words, to be human is to be sexual, which informs us that humans are divided into two sexes for the purpose of procreation.

In the early 1900s, as "sex" was being used to refer to the act of intercourse, "gender"—previously only a grammatical term—was enlisted as a synonym for "sex" as either male or female. In the early 1960s, feminists expanded the meaning of "gender" to include social and personality traits associated with each sex. The debate between the modernists and postmodernists has typically been over the etiology of these traits: biology or social forces. In time, the postmodernists argued that gender is an entirely subjective sense of self unrelated to the sexual difference in the body and that it should have priority over the body in determining identity. Despite the evolution of language, an etymological study of "gender" reveals its original meaning. The Latin root is *gen*, which means "to beget, give birth." From this root, we get the words genus, genetic, generous, generate, genital—all of which carry the meaning of production after one's own kind. Therefore, "gender" and "sex" may be interchangeable so long as we are referring to a kind or class of persons based on the manner by which they generate. It would be more accurate to refer to the personality and social generalities of the sexes as gender-based or gender-associated traits or stereotypes (for lack of a shorter term).

Regarding the word "identity," the current trend is to understand identity as one's subjective self-concept, which may be based on innumerable factors. But the Latin root is *idem*, which means "same." Therefore, the traditional, essentialist understanding is that identity is an objective self-concept, based on possessing the same essential traits shared by members of the identity group. When we see plainly the integration of body and person, it is clear that there are only two sexual (or gender) identities: male and female. And one is identified as male or female by the essential trait of possessing either male or female reproductive systems. One may not fit the culturally determined norms or stereotypes for one's sex—or even the bodily norms of secondary sex characteristics—but that does not negate the fact of one's maleness or femaleness. Ironically, Queer Theory reinforces rigid stereotypes by basing identity on personality and social traits instead of the body (Pearcey, 2018, p. 198).

As an aside, the commonly heard conservative retort to transgenderism, "If you have XX chromosomes, you're female; if you have XY chromosomes, you're male," may seem certain, but is actually inaccurate. In cases of persons with CAIS (complete androgen insensitivity syndrome), the person has XY chromosomes but has a defect that makes the genes nonresponsive to the testosterone that develops the male sexual reproductive system. Therefore, the individual develops female genitalia, but lacks a uterus and remains infertile. Though the exceptions should not prove the rule, we nevertheless

must account for them. We can best solve this dilemma by considering the most universal, timeless approach. Since genes can be discerned only in a laboratory in the modern era, they do not serve as practical determinants of identity. The observable body (the phenotype) is the actual product, and the genes (genotype) are the blueprint to achieve a particular identity which may or not get activated. Just as with a physical building, the blueprints may show one plan, but the building itself is not the blueprint.

At face value, the term "sexual orientation" may seem obvious: the direction of one's sexual attractions. But when we consider how sexual arousal feelings and desires can change (Pela & Sutton, 2021) and how they may be based on complex idiosyncrasies and how they may be out of synchrony with one's self-concept (identity), the idea of defining orientation by one's attractions becomes untenable. Though the popular framework is to conceive of sexual orientation as a fixed category, this is a faulty and outdated paradigm. As early as 2002, lesbian psychologist Linda Garnets proposed a new paradigm that understands sexual orientation as comprising continuums of the dimensions of attraction, behavior, and identity. But even with this consideration, there is no consensus in the research community about the most accurate and reliable way to conceptualize and operationalize the construct of sexual orientation. It would be wisest to reject the construct of a "sexual orientation" altogether or to reformulate it based on the design of the body, which clearly shows that humans are oriented toward sexual union with the complementary sex. The experience—however persistent it may be—of contradictory romantic or sexual interests, arousal, behavior, or ideas about one's identity does not negate the reality the body reveals.

What kept us from disintegrating into sexual identity chaos sooner in history? Despite the Enlightenment relegating religion to the private sphere and creating the subsequent is/ought split, society still honored the phenomenon of Natural Law for quite some time. Even societies that have not emerged out of Christendom, such as those from Buddhist cultures, may adhere to an understanding of innate design and purpose for structures in the body (Berzin, 1998). Yes, though fallen humanity has perpetually been living in rebellion or denial of the truth known from general revelation, the new form of paganism resulting from the modern Sexual Revolution is especially unaware of such revelation, blinded by generations of secular sophistry and stark dualism. Despite the increased challenges, we nevertheless make our appeal to a post-Christian world in the same manner the apostles did when witnessing to Gentile nonbelievers, by pointing out what they already knew through nature and reason (Acts 14:16-17; 17:22-31) (Budziszewski, 1997). Otherwise, we neglect our call to deliver God's message of reconciliation to lost people (2 Corinthians 5:16-21).

Application for Human Services

The church, whether in dealing with its members or in dealing with the surrounding culture, must be secure in its own understanding of human sexuality. As Joe Dallas has stated (Central Assembly, 2022), the church fails in its mission when infected with worldliness, thus reflecting the attitudes of the current zeitgeist. There was a time when the larger society held open, vehement contempt for homosexuality and gender nonconformity,

and a portion (perhaps a significant one) of the church reflected that same attitude. The church may have been doctrinally correct in upholding the prohibition against homosexuality, but in taking cues from the secular modernist world, the prohibition lacked the true purpose of our sexuality and the church sacrificed its virtue of compassion. As the Sexual Revolution progresses, however, the church is in danger of taking cues from the postmodernist world and sacrificing truth for the sake of niceness or social acceptance. In either extreme, the church is rendered ineffective at delivering the Gospel's message of redemption. In a perpetual quest for cultural relevance, the church loses its identity, authority, and usefulness, forgetting that the church's own message is eternally relevant and cross-cultural because it gets to the core of what it means to be human.

The reader may have noticed that I argued for the historical, orthodox Christian vision of sexual and gender identity without relying on the so-called "clobber passages." Although sound exegesis of these verses would still support the viewpoint presented, the reality is the biblical view of sexuality is not reliant on these verses. "It is based on a teleological worldview that encourages us to live in accord with the physical design of our bodies. By respecting the body, the biblical ethic overcomes the dichotomy separating body from person. It heals self-alienation and creates integrity and wholeness. The root of the word integrity means whole, integrated, unified—our minds and emotions in tune with our physical body. The biblical view leads to a holistic integration of personality. It fits who we really are" (Pearcey, 2018, p. 30).

Unfortunately, the church is currently split in several ways over how to address sexuality. In particular, one stream—found in "side B gay Christianity" and the Revoice conference—validates LGBT self-concepts while attempting to support the orthodox Christian ethic regarding behavior while opposing interventions to aid in changes in thoughts and feelings. Therefore, if someone in a natural marriage experiences same-sex eroticization, the marriage is considered a "mixed-orientation marriage." Another stream, seen especially in Evangelicalism, is to view the thoughts, feelings, and behaviors all purely as sin in need of repentance (Cook, 2022). Both views outright oppose or dissuade individuals from seeking understanding and healing of the roots of their particular dis-integration.

However, as John Paul II notes, love aims at integration within the individual, as well as integration between persons. The process of integrating the components of love (attraction, desire, and goodwill) relies on the primary elements of the human spirit—freedom and truth (Wojtyla, 1981, p. 116). Therefore, we must advocate for the rights of clients to have self-determination and access to counseling services that align with their values, as well as advocate for policies that reinforce the true meanings of our bodies, sexuality, and marriage.

As people blessed with the true conceptualization of personhood, we must contribute to the cultural conversation by engaging with confidence in our worldview and in compassion for those whose worldviews inevitably lead to destruction. Our worldview is radically positive and affirming (Pearcey, 2018, pp. 216, 204). We can be certain that a world that adheres to the principles and conclusions of our integrated sexual ethos and ethic will be better for it. Therefore, we do not merely defend "traditional values," for it just takes enough time for faulty ideas and practices to become traditions. Instead, Christianity

has always stood for the true, good, and beautiful regardless of the cultural trends (Pearcey, 2018, p. 188).

"Normality is *that which functions according to its design*" (Nicolosi, 2016, p. 16). Therefore, deviating from design constitutes abnormality. It follows then that humans (and all creation) function best and flourish when adhering to higher organizing principles. The subjective self is not sovereign over reality. When Christian clinicians and civil servants are convinced of such truths, they have a foundation for authentically compassionate care. For we cannot assist people if we do not have a concept of helping that is not rooted in reality.

The way to love people is by supporting the genuine good of their telos, no matter the risk to one's reputation or even professional license. Doing good for others will require courage in these days. The Enemy believed he could silence the message of the Gospel through the Enlightenment, relegating religion to the realm of the private and subjective where it has no impact on public life and policy. As Pearcey notes, the Roman Empire did not persecute the Gnostics—with their privatized, escapist spirituality—like it did the Christians because a religion that applies solely to the private realm does not threaten the system in power (2018, p. 39). Likewise, it is the books and counseling services that promote transformation, sexual attraction fluidity, and reintegration with the body that are being ostracized socially, banned from the market, and outlawed by the state.

We can stand firm against accusations of harm so long as our praxis follows our established ethos. Compassion based on truth does no harm. Conversely, we see numerous risks of harm in both homosexual behavior and transgender affirmation (especially as it becomes medicalized). When we disrespect ontology and the teleology of the body, we do violence unto ourselves. This is evident in the medical risks inherent to homosexual behavior. The Centers for Disease Control and Prevention (2023) report that men who have sex with men comprise 70% of newly HIV-infected men. The Gay and Lesbian Medical Association (2023) acknowledges the increased risk for gay men of HIV, hepatitis, other STIs (including HPV, which could lead to cancer), substance abuse, depression, and anxiety, as well as prostate, testicular, and colon cancer.

If God has a normative standard for our sexuality, then he has a normative developmental process. In our fallen world, one does not inevitably mature into adulthood fully aligned with God's design and prepared for a loving marriage. It must be nurtured. Our natural design affirms how a child needs love and nurture from both a mother and father, in specifically feminine and masculine ways (Doyle, 2018. 87). Just as all of humanity's sexual integration was broken by the broken attachment with God, so individual sexual brokenness is rooted in broken attachments. Our attachment losses result in shame and alienation from self and others (Nicolosi, 2016).

As clinicians and ministers, our responsibility is to aid families in the developmental process and help individuals understand the roots of their dis-integration and then heal from their wounds and losses. True therapy is reparative in nature, not affirmative of every idea a client may have about his or her identity, behavior, or relationships. We do this all from the standpoint that "[w]e are all broken gifts, aspiring together to become beautiful in our self-giving" (Comiskey, 2015, p. 25). We are one human family and each of us are at different stages of integration.

As civil servants and concerned citizens, we advocate for reality-based policies. We understand the stakes of society-wide rupture of the union of body and spirit. It leads to a culture of death. When we fail to respect the truth that genitals are meant to generate, civilization degenerates. And when our societal institutions do not support normative development, our next generation suffers. LGBT activism is justified in advocating for humane treatment that protects the dignity of each person, but the movement undermines its own cause when it concerns children in two critical ways.

The promotion of queer ideology at all levels of education and the media inhibits children from maturing into integrated adults. Children and adolescents are highly susceptible to influence. Public normalization and celebration of LGBTQ identities and relationships steers them toward a developmental trajectory that objectively deviates from the good of their biological design and will ultimately be for their ill. This is especially evident in the fast-tracking of social and medical "transition" among youth with gender dysphoria, most of it rapid onset. The violence committed against their bodies in the name of "gender-affirming care" is long-lasting and irreversible in most cases. The political forcing of affirmation of gender identity in sex-segregated private spaces (restrooms, locker rooms, prisons, shelters) leaves females, in particular, vulnerable to males with predatory intent. And for other children subjected to requirements to deny what their physical senses inform them about the identities of classmates and teachers, they suffer disruption in the development of their sense-making capacities. When we deny the teleology of our bodies and its goodness, we experiment on the most vulnerable in our society. And there is no recourse when it is all done in the name of justice for a minority class.

Parents who dissent from the prevailing LGBT ideology are now in need of the protection of their natural rights. As compassionate guardians of truth, we must come to the aid of parents who desire God's design and intent for their children. The state has been taking action against parents who are not affirming their children's alternative gender identity, labeling them as unfit or abusive. This is an inevitable outcome of the postmodernists' denaturalization of gender. "When gender is de-naturalized, parenthood will also be de-naturalized" (Pearcey, 2018, p. 213). Parenthood itself will not be determined by nature but by the will of the state, granting parents only legal rights as the state sees fit.

The indoctrination of society that homosexual partnerships are the same as male-female unions is a marvel of social engineering. The reality of the natural order quite easily informs us that a natural marriage is the sexual union of a man and woman, which alone has the potential to build a family, the basic unit of civilization. The Christian vision of sex and marriage predicts that this model—of children being reared in the home by the two adults who conceived them in a loving marriage—will have the greatest likelihood of facilitating the development of persons who are secure in their gendered identities and prepared to contribute to the continuance of society. It stands to reason, then, that variations of departure from this model will have deleterious effects on children. Nevertheless, gay marriage advocates are adamant to assert that homosexuality is a normal variant of human sexuality no different from heterosexuality.

Children then become commodities used to validate the sameness of gay partnerships. A biblical anthropology predicts that this does not serve the good of

the child. In a surrogacy or sperm donation arrangement necessary for conceiving children for gay partners, the child experiences the loss of at least one of the genetic parents, if not also the mother who gestated the child. As Katy Faust's (Faust & Manning, 2021) work extensively shows, children in the homes of gay parents suffer a void. Children have a natural right to be known and loved by both their mother and father, who are both necessary for parenting. An abundance of research shows the negative outcomes highly correlated with being raised in a home without one of the parents or being raised in a home with a non-biological parent. Children raised in same-sex parent homes suffer not only that loss, but additionally the loss of gender complementarity represented in the parents, which is another essential factor for healthy development (Faust & Manning, 2021, p. 121). Social services demonstrating preference for male-female marriages is not necessarily bigotry against gay couples. We must protect the rights of children, which requires adults to make the difficult choices of foregoing their own gratification and pursuing the good of vulnerable children.

Despite the propaganda of "no difference" from male-female parent homes, same-sex parent homes are correlated with disastrous outcomes for children. The largest study on the topic (Sullins, 2015) shows that children of same-sex parents are over twice as likely as children from opposite-sex parent homes to suffer emotional or behavioral difficulties, even with no difference in experiencing bullying. Schumm's extensive investigations (2018) into the research reveal how the science on same-sex parenting is concealed or distorted to fit the approved narrative. We are at a loss for more population-wide data, particularly when it pertains to abuse, because government agencies that track child abuse do not also track the abuser's sexual orientation. Nevertheless, the children of these homes become adults and tell their stories, reporting statistically significantly higher incidents of poverty, mental illness, infidelity, sexually transmitted infections, sexual victimization, and drug use in their homes growing up (Regnerus, 2012).

The practical application of Theology of the Body and Natural Law in the human services can be explicated ad infinitum. What I hope I have accomplished in this paper is provide a foundation for further praxis and a rationale for holding to Christian distinctives in the face of immense cultural, political, and occupational pressures. Above all, I hope that the reader has gained an assurance that the authentically Christian vision of sexuality is the most holistic, comprehensive, rigorous, loving, and compassionate approach and the one the world desperately needs, as it reorients us to God's design, desire, and destiny for us. May we all hold to it with integrity.

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Review of Miriam Grossman's *Lost in Trans Nation: A Child Psychiatrist's Guide Out of the Madness*

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Dr. Grossman's stated aim in *Lost in Trans Nation* (2023) is to equip (or better, *arm*) parents of adolescents with critical scientific and background information that can assist them both before and after their child declares a trans identity. Her focus is particularly on the Rapid Onset Gender Dysphoric (ROGD) minor. She pulls no punches and provides her audience with helpful practical advice.

Grossman opens begins her book with her summation of the "Articles of Faith" of current gender ideology. I will list them here since they are foundational to her critique:

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Mariam Grossman, M.D., is board-certified in child, adolescent, and adult psychiatry. The author of five books, her work has been translated into eleven languages.

1. Behold GENDER IDENTITY; it liberated you from oppression, from the harsh constraints of biology.
2. GENDER IDENTITY is sacred; thou shall not question it; thou shall not turn away from it to hard science, for GENDER IDENTITY is jealous and cannot tolerate the scientific method.
3. Remember GENDER IDENTITY, to keep it holy. Behold, it is both fixed and fluid; healthy and needing drugs and surgeries; do not admit the contradictions.
4. Thou shall consider "male" and "female" arbitrary assignments; thou shall deny their establishment at conception.
5. Thou shall affirm all gender identities with all your heart and all your soul, so that you will be an ally and keep your livelihood.
6. Do not misgender.
7. Do not deadname.
8. Thou shall not explore anxiety, ADHD, trauma, or autism; thou shall always invoke the minority stress model.
9. Thou shall honor the self-diagnosis and judgment of minors and young adults. Thou shall not recognize their emotional and cognitive immaturity.
10. Gatekeeping is an abomination. Thou shall therefore scorn psychotherapy, and place your trust in breast binding, penis-and-testicle-tucking, pills, patches, syringes, scalpels, implants, and prosthetics.

Grossman then proceeds into a withering critique of these ten commandments and those medical and mental health professionals, medical and mental health associations, educators, lawyers, and politicians who have incorporated gender ideology into their way of orienting to the world.

Grossman traces the professional origins of the current gender ideology to John Money. In Chapter 1, she provides a fairly detailed history of how Money originated and popularized the notion that one's personal identity could be completely divorced from biology. The author makes it clear that Money's interests were clearly connected to his personal depravity and provides ample evidence for this linkage. Grossman continues with this theme in Chapter 2, where she outlines how Money's ideas began to take over professional organizations in the early 21st century. She includes a discussion of the history of the Diagnostic and Statistical Manual (DSM), which categorizes psychiatric disorders, with particular focus on the DSM's evolution from Gender Identity Disorder to the current Gender Dysphoria.

Grossman's writing style is to introduce topics through case material. In chapter 3, she does this to help make real the explosion in gender dysphoria cases, particularly of adolescent and young adult females of the ROGD variety. She outlines

the work of Dr. Lisa Littman, whose pioneering study of ROGD led to severe professional ostracization. Grossman turns her focus to the professional associations in chapter 4 and provides evidence that their denouncement of ROGD and support for so-called "gender-affirming care" (GAC) actually represents a "Castro consensus", so named for the consensus Fidel Castro achieved in his governance by banning opposition. She expresses particular ire toward the American Academy of Pediatrics but believes all of the major professional groups are acting as a "…monolithic mouthpiece regurgitating the Articles of Faith" (p. 52). She also notes the irony found in the trans advocates logic that, "The rates of transgender-identifying teens have skyrocketed because society is more accepting, but those same people who are more accepted suffer from anxiety, depression, and increased suicidality because….there's so much transphobia" (p. 54).

Chapter 5 provides a deeper dive into Jamie Reed's firsthand accounts of the "treatment" that she witnessed for the four years from 2018 to 2022 when she worked as a case manager at the Washington University Pediatric Transgender Center at St. Louis Children's Hospital. Grossman intersperses whistleblower Reed's observations with her own perspective on how such gender clinics are failing these children by, among other things, providing irreversible treatments based on low or very low-quality evidence, including creating "synthetic puberty" via puberty-blocking drugs that can lead to sterility when followed by cross-sex hormones, which almost always occurs.

Grossman addresses the Dutch Protocol in Chapter 6, which constituted the original GAC model. The author notes that the Dutch Protocol was based on a single study which has never been replicated. She proceeds to methodologically shred this study by outlining 11 serious flaws, leading her to subsequent comment:

> When you hear confident claims from the gender medical establishment claiming the science is settled, remember: the widespread use of puberty blockers and hormones is based on a study riddled with deficiencies and bias, some of the original authors openly question why ROGD kids are being treated under their model, and two prominent advocates of GAC who themselves identify as transgender, call it reckless and sloppy. (p. 88).

Grossman also addresses the scandal that occurred with the Tavistock Gender Identity Disorder Service in London, which was recently closed down by the National Health Service.

In Chapter 7, Grossman addresses her concerns about psychiatric and behavioral health facilities serving to solidify a trans identity. She provides a very helpful hypothetical conversation between a hospital psychiatrist, a case worker, and a concerned parent to coach parents on how they can best interact with these professionals when they express the talking points derived from the "Articles of Faith." She also debunks the "affirm-or-suicide" narrative that parents are very likely to hear in such situations. Grossman then turns her attention in chapter 8 to the role of educators in the propagation of gender ideology in schools. She addresses the dangers of social transition, noting that Dr. Kenneth Zucker considers social transition to be an active psychosocial intervention that schools and other institutions are

unqualified to implement. She describes some of the organizations most involved in resourcing schools in all things gender and exhorts parents to be "vigilant and proactive regarding schools" (p. 128).

Lawyers are the next target of Grossman's concern in Chapter 9, and she describes some of the legal threats to parents. The author is up-to-date in her discussions of current case law and recent court cases that have bearing on the challenges parents may have to navigate. Chapter 10 discusses the neglected but real experience of what Grossman considers parental trauma when children trans-identify:

> But no one has recognized parents were victims of actual trauma and their symptoms were serious, even debilitating. Not only that, but unlike a car accident or hurricane, where trauma is due to a single event, the ordeals these parents face are ongoing, typically lasting years. (p. 144)

In chapter 11, Grossman takes to task the medical profession for its use of relatively benign-sounding euphemisms for serious medical procedures, e.g., "'Top surgery' is a euphemism, of course: what they're talking about is breast amputation, a bilateral mastectomy" (p. 157). Here she also addresses and challenges assertions of a low regret rate, the harmlessness of breast binding, and offers her view on how so many people have come to embrace gender madness, boiling it down to two factors: (1) it is a vision of radical social reform and (2) it is about money.

Chapter 12 details the many complications that come with medical surgeries, from mastectomies to phalloplasties to vaginoplasties. Grossman has particular disdain for the World Professional Association for Transgender Health's (WPATH) role in the promotion of GAC and she provides valuable history for understanding how the organization has been captured by trans activists. The author also describes WPATH's latest version of its Standards of Care (SOC-8) and observes in the SOC-8 that affirmation is the only solution for gender dysphoria, counseling should never be mandated, age restrictions have been removed, and boys and men seeking castration ("eunuchs") are now recognized in the standards as validly seeking to affirm their gender-nonconforming identity. Grossman notes: "Too many believe this is all about compassion, respect, and rights. That's a cover. The goal has always been the breakdown of norms….there is no endpoint. *The thrill is in pushing beyond the acceptable*" (p. 195, author's emphasis).

Although the book is directed toward parents, the final chapter (12) is of particular interest to clinicians who work with or may encounter a gender dysphoric minor who claims to be transgender and/or non-binary. In this chapter, Grossman gives insight into how she works with these minors in her practice and gleans from this several lessons for parental engagement with their trans child. These include being present and listening, dealing with gender ideology talking points regarding statistics, studies, and suicide, and handling accusations of being transphobic. The author again provides excellent hypothetical examples of such conversations that are likely to be helpful to parents who are navigating these discussions with their child. I felt my own sense of clinical validation in Grossman's encouragement for parents to take an attitude of curiosity, prioritize maintaining

an attachment to their child, self-regulate their emotions well so as to be non-reactive and keep the long-term picture in mind by planting seeds that can sow doubt in the minor's thinking about the fixed nature of his or her trans identity. For example, when a minor states she is a boy, a genuinely curious response might be, "I can't help but wonder, how do you know what it feels like to be a boy?"

Grossman concludes her book with some stories of clinical success while acknowledging that this is never guaranteed. She also summarizes the advice she has heard repeatedly from parents dealing with a gender dysphoric child, which is worth mentioning here:

1. Discuss gender with your child early.
2. Get out of public schools.
3. Get your child off the Internet.
4. Know who your child's talking to—at school, online, everywhere.
5. No social media, smartphones, gay-straight alliance meetings, gender clinics.
6. Love without affirming. No names, pronouns, binders. Validate feelings, not beliefs.
7. Be vigilant.
8. Don't think it's not happening in your area, because it is.

I would add a tenth recommendation. I tell my parents: give your child attractive models of traditional identities, i.e., being a good woman or man, mother or father, wife or husband, Christian, etc., as these identities can provide some inoculation (though not a guarantee) against gender ideology.

Finally, Grossman provides several appendixes that give practical guidance for parents in terms of key scientific studies, dealing with schools and child protective services, finding a therapist, and finding good Internet accountability tools. My only criticisms of Grossman's writing have to do with her rare allusions to sexual orientation, which seem to view it as a universally fixed phenomenon, and the lack of a subject index, which would have made it easier for readers to go back and review specific information they might later want to revisit. Overall, however, *Lost in Trans Nation* is a highly valuable resource for parents and one with which clinicians should be familiar.

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Review of Bryan Shen's *Re-affirming the Core: Understanding the Issues Surrounding the Way Out of the Storms*

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At 227 pages, this is a fitting sequel to his first book, *The Un-Affirmed Core,* which was reviewed in Volume X of the *Journal of Human Sexuality* in 2018. In his first volume, Shen strove to remove misconceptions, prejudice, and negative attitudes by people in religious communities toward those who experience homosexual attractions. In this volume, Shen addresses what those in religious communities can do to help them. Much more highly illustrated and containing 40 scientific references, as well as a glossary of terms, this volume is geared toward mental health therapists, pastoral counselors, mentors, and life coaches.

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Bryan Shen is a registered professional counselor with the Singapore Association of Counselors who obtained his Masters in Social Science (Counselling) from the University of South Australia in 2010. He is also a registered supervisor of counselors.

With endorsements by authorities in both Muslim and Catholic communities, Shen skillfully navigates religious aspects related to this topic while acknowledging the presence of universal needs. The book is not written for those who value their same-sex erotic attractions. Skillfully illustrating points in the book with twelve case studies, Shen carries on the tradition of the first book.

In the introduction, Shen highlights the fact that there are common needs and inner voids existing internally in all non-heterosexual people, regardless of the community they identify with or in which they feel comfortable. There is also a brief description of the theme and contents of each Chapter. In Chapter 2, Shen posits that non-heterosexuality centers in the emotional brain which is non-logical in nature. He points out the differences between same-sex attraction and gender dysphoria.

In Chapter 3, people with non-heterosexuality are grouped into common patterns of behavior and how that plays out in their lives. Rather than viewing this as an effect of non-heterosexuality, I view them as various psychological defects that have their own relational manifestations and result in non-heterosexuality due to the lack of healthy emotional-relational development.

Chapter 4, entitled, “Research on Sexual Minorities” by Eliza Lian-Ding, PhD, will be especially esteemed by academicians. In the debate between nature and nurture, the science now quite clearly comes down on the side of nurture. The argument that one is “born that way” has been discarded by science but, to be clear, for any individual they are not perceived as “chosen” either. Adverse childhood experiences are two to three times more common in non-heterosexuals and addressing these appropriately in therapy is being used effectively and not found as harmful by those seeking therapeutic help. Indeed, earlier suggestions that such therapy increased suicide were found to be faulty in their analysis and instead showed decreases in suicidality as a result of therapy. Ding also carefully reviews the latest scientific data related to gender dysphoria and transition attempts.

Chapter 5 deals with positive and negative effects and why various addictions often accompany the person dealing with non-heterosexuality and how the right kind of affirmation can help. It also delicately addresses the story behind the story of non-heterosexuality within certain religious institutions. Chapter 6 discusses various therapeutic approaches that have been used to help those desiring help with non-heterosexuality as well as some of the benefits and disadvantages of support groups for affected individuals and their parents and loved ones.

As a Catholic living in a Muslim world with a significant percentage of other Eastern religions, Shen has a unique perspective on how each deals with the question of non-heterosexuality. In Chapter 7, he advocates for studies to prove that more people with non-heterosexuality gravitate to and become involved as leaders in all of these religious groups, despite none of them claiming to be “gay” or openly admitting their feelings. Shen advocates for better mental health assessment of prospective trainees in religious organizations, premarital counseling, adoption, and outcome studies of success or failure in heterosexual and non-heterosexual marriages.

In Chapter 8, dealing with government and civil leaders, Shen condemns blanket bans on therapy for non-heterosexuals who desire change in the intensity or direction of their feelings. He also points out emerging data that shows children raised in

non-heterosexual homes compare unfavorably to those raised in traditional heterosexual ones. He offers four overall suggestions for improvement in how civil authorities address LGBTQ issues. Parent-child interactions where children experience non-heterosexuality are addressed in Chapter 9 with advice for counselors who face any combination of parent or child attitudes toward these issues.

Chapter 10 includes helpful tips for individuals who experience non-heterosexuality and desire change for self-care and improvement in relating to others. It also addresses how those who experience non-heterosexuality and are at peace with it can allow education and help for those who experience it and desire help. Included is a section of siblings which is also instructive.

I found the Q&A Chapter 11 the weakest one, especially Shen's answer to the first question. While the goal of good therapy is not to change sexual orientation good therapy properly applied and acted out by the individual invariably helps them move toward what is real and true about their sexual selves whether male or female. Judgement of success by a person who has never experienced non-heterosexuality is improper and improvement in all types of relationships for persons dealing with non-heterosexuality is always a welcome outcome. Shen's views on politics and LGBTQ issues also fail to consider a balance between long-term societal goals and individual freedoms or the role of society in setting standards which may benefit a marginal group in preventing harm. Shen's conclusion is insightful and gives hope for a future book to deal with how we fix the damaged core.

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Review of Patricia Morgan's *Banning Conversion Therapy: The Missing Evidence*

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The backdrop to *Banning Conversion Therapy* (2023) is the current legislative effort in the United Kingdom to ban CT, which as of this writing remains in process. Morgan's work, published by Wilberforce Publications, is an attempt to influence the debate by raising questions and providing scientific and important background information largely missing from public discussions on the topic. The book is broken up into five chapters.

The first chapter addresses a lack of specificity or clarity regarding what is actually being banned in the proposed legislation. The second addresses the contrasting perspectives of sexual orientation as fixed or fluid. Morgan observes the expedient but often false narrative ban advocates assert that sexual orientation and gender identity are fixed and unchangeable, despite evidence to the contrary.

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Patricia Morgan is a sociologist and former Senior Research Fellow at the Institute for the Study of Civil Society specializing in criminology and family policy. She has written several books and articles on these topics since 1978.

In Chapter 3, Morgan outlines some of the ironies of the government wanting to ban practices that are not being offered by practitioners (e.g., coercive, aversion-based, etc.) while allowing practices such as new age healing and holistic treatments that might lead a person to forgo necessary medical care as well as "natural" childbirth, which may have contributed to many deaths. Here I am pleased to say she quotes this reviewer in a couple of instances and goes into some detail about the travails that Alliance board member Michael Davidson has had to endure owing to his non-profit organization, Core Issues Trust, which is dedicated to helping resource those struggling with unwanted same-sex attraction. She observes that "…those campaigning for a comprehensive 'conversion therapy' ban seek to criminalize virtually anything other than total acceptance and reinforcement of particular sexual or gender identification, for child and adult alike" (p. 102).

Morgan focuses particularly on alleged harms and relevant research in chapter 4, including Sullin's reanalysis of Blosnich et al.'s population-based data regarding (among other things) the alleged connection between sexual orientation change efforts (SOCE) and emotional harms. In this chapter, Morgan cites much of the SOCE literature suggesting SOCE is an effect rather than a cause of this harm. She is familiar with most of the recent research pertinent to these issues and describes some of it in detail.

A final chapter examines Morgan's perceptions of the reasons behind the surge in cases of adolescent gender dysphoria in the last decade and the details of the "recruiting drive" behind this. The author notes, "In an extraordinary and alarming paradox, therapeutic support that mutilates and amputates body parts to "transition" may not be considered to be 'conversion therapy', but talking therapy is" (p. 172). Morgan also provides some limited view of where this debate on SOCE could be headed, observing, "Throughout any examination of demands for bans, it is hard to avoid how it is moral and religious perspectives that are primary targets" (p. 187). She concludes by writing,

> "The proposed prohibitions are serious threats to freedom of choice and speech. They have wide-ranging potential for considerable interference in many aspects of personal and social life, including the welfare of children and vulnerable adults who are put at the risk of exploitation and life-changing injuries to appease ideological aspirations. Based on the evidence, any ban on so called 'conversion therapy' must be rejected" (p. 190).

Overall, Morgan's work provides a good overview of much of the SOCE literature, including especially research and commentary more sympathetic to speech-based SOCE. My main qualm with the book is that Morgan's organization of the information is not tight enough and in places it is not so clear why certain information is being placed in one chapter over others. In addition, the author has a habit of asking strings of questions that deserve some answer in response that may not be forthcoming. Yet *Banning Conversion Therapy* is a good introduction to the issues and literature surrounding attempts by governments to prohibit change-allowing therapies, albeit in a decidedly British context.

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Review of Mark Yarhouse and Olya Zaporozhets's *When Children Come Out: A Guide for Christian Parents*

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Yarhouse and Zaporozhets authored this book (published in 2022) "…to help the church be better positioned as a resource to Christian parents navigating difficult terrain" (p. x). They further indicate that their work specifically utilized their survey research with Christian parents in order to examine the coming-out experience of LGBTQ+ people. This book contains helpful insights for parents navigating the journey of a child coming out, but there remains significant concern that I will identify later in this review.

The authors break up the book into chapters that are essentially sequential in the process of a child declaring a gay and, to a lesser extent, transgender identity. Chapter 1 describes how parents become aware of their child's sexuality. The authors make the distinction between finding out via disclosure or discovery, stating that the latter means is much more common. They also remind readers that same-sex attractions are not experienced as being chosen and that to love and accept your child is not necessarily the same as affirming their LGBT+ identity.

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Mark Yarhouse, Ph.D., is a licensed clinical psychologist and Professor of Psychology at Wheaton College, where he directs the Sexual and Gender Identity Institute. Olya Zaporozhets, Ph.D., is an associate professor in the School of Psychology and Counseling at Regent University.

Chapter 2 examines how parents seek help and outlines two tasks parents have post-disclosure; namely, seeking help and maintaining the relationship. The authors encourage parents to examine their beliefs about same-sex attractions and behaviors. They observe that such reflection does not usually lead to substantial changes in parents' viewpoints, but it often leads to greater nuance and empathy. In Chapter 3, "How Parents Maintain the Relationship", Yarhouse and Zaporozhets rightly encourage parents to emphasize love for their child and to affirm their dignity and worth. They note that disclosure is an invitation and opportunity for parents to get to know their child better as well as time to emphasize listening. This chapter, as in others, concludes with a section of advice from parents compiled by the authors, including focusing on the here and now, avoiding being judgmental, and engaging in productive communication, especially listening and asking genuinely curious questions.

Changes that occur over time in the parent-child relationship are the focus of Chapter 4. The authors reported that conflict tends to increase initially but decreases over time as well as does anger. Emotional closeness, communication, engagement, authenticity, acceptance, and protectiveness all often decrease initially but tend to increase over time. In Chapter 5, the authors describe how parents' faith changes. They report that Christian parents tended to believe that same-sex attractions and behaviors are sinful, but many came to question this belief over time. In their sample, 86% of parents originally believed same-sex attraction and behaviors were sinful, but 35% of these parents shifted their beliefs, although many (65%) did not. The authors tellingly note that most parents who believed same-sex attractions and behaviors were not a sin also believed that God made their child this way.

In Chapter 6, How Parents Come to Terms with Reality, a sound piece of guidance is that fear-based responses to value differences between parent and child will not lead to a better relationship. The authors observed in their research that parents cognitively moved from a place of confusion to a place of insight. Emotionally, parents made adjustments to reduce conflict and negative emotional experiences (e.g., less fear-based responding) and grew in positive emotional experiences (e.g., love, emotional closeness, engagement). A final chapter describes what advice the authors' parent sample would give to the church in order to help. This guidance includes (a) lead with love, graciousness, and humility; (b) really "see" the child; (c) educate the church; and (d) offer parental assistance. They also encourage churches to be clear about their doctrinal positions rather than hide them in order to be seeker sensitive. To do otherwise, the authors correctly assert, is to set up the LGBT+ person for a negative experience of "bait and switch." These parents want the church not to be reactive to the person coming out, but rather proactive now in shaping the church climate.

Although there is a reasonable amount of good advice in *When Children Come Out*, there are also several limitations of which especially the traditionally Christian reader should be aware. First, one has to consider the significant limitations of the sample on which the authors are basing their work. Their sample consists of 121 parents, so when comparisons are made, the cell sizes can be quite small. Furthermore, this is a sample of parents whose child has come out as LGBT+, meaning that parents whose children report same-sex attractions but not a gay identity are overlooked. The authors

acknowledge on page 100 that their sample is likely not representative, but more should be said. The aforementioned considerations mandate that the findings and hence guidance of this sample not be confidently generalized beyond this sample, which obviously is not taking place in a book marketed to the general Christian public.

This observation connects with a broader issue in the approach the authors take to the topic. Readers need to know that this book is not written prescriptively but descriptively. In other words, the authors take no position on the subject matter that might guide more specifically parents who desire to maintain their traditional faith-based values and beliefs. Rather, they describe a range of responses parents in their sample make and leave the rest up to the reader. Since this is a sample of parents with children who identify as LGBT+, this range of responses includes options that might lead traditionally Christian parents to more generally question the guidance they are being given. For example, without comment, the authors note, "For some Christian parents, their commitment to unconditional love even meant they were open to leaving their faith in order to love their child" (p. 16). There is no reflection given to what might legitimately constitute unconditional love within a traditionally faith-based worldview. On page 78, the authors highlight "…an example of a parent whose beliefs and values changed over time toward a theological view that affirms same-sex marriage." Elsewhere, a parent whose child identifies as transgender states, "I know one hundred percent that this is a medical condition, [my transgender son] was born this way" (p. 55). The authors follow up this statement by commenting "Because we do not know how diverse gender identities come about, answer to these and other questions will vary" (p. 55). Again, there is much more scientific nuance and a growing clarity to these matters than this sample of parents is able to provide.

Another reason why the authors seem to make such efforts to avoid offering a specific position on many issues of salience to traditional Christian parents is their repeated discounting of psychodynamic and trauma considerations in the development of non-heterosexuality. While the authors' caution against blaming parents for their children's sexuality is wise, this should not preclude curiosity in understanding the etiological role these factors may play. There are likely multiple pathways to same-sex attraction and gender dysphoria, but rather than simply stay agnostic about causation generally, Yarhouse and Zaporozhets frequently emphasize what *cannot* cause non-heterosexuality and transgender identity; namely, experiences of trauma or certain psychodynamic considerations.

> Parents who struggle with blaming themselves for their child's same-sex sexuality are often responding to a common theory of causation subscribed to by many conservative Christians. According to this theory, a child attracted to the same sex must have experienced a failure to identify with their same-gender parent, creating an emotional longing that later became sexualized…We do not subscribe to this theory…" (p. 19).

Similarly, the authors observed that for their parents, ex-gay resources were generally unhelpful.

> Proponents of an ex-gay approach usually espouse theories of causation that implicate past trauma or a failure to identify with one's same-gender parents. These claims often propose a corresponding path to heterosexuality through resolving the negative emotional consequences of trauma or addressing unmet needs tied to apparent-child emotional deficit. Parents who found these resources unhelpful also felt that other parent-blaming approaches …were unhelpful. (p 40)

This treatment of etiology is woefully inadequate. In my opinion, causation should not be a zero-sum game between nature and nurture and clinicians should remain curious and open to considerations of a traumatic and/or psychodynamic nature.

It is worth noting in this context that the authors include frequent sidebars in the book highlighting direct statements from parents presumably from their sample. The two most frequently quoted sets of parents are Dave and Jean Coles and Lynn and Greg McDonald. The Coles son, Gregory, is a Senior Research Fellow at the Center for Faith, Sexuality, & Gender, whose President is Preston Sprinkle. Coles and Sprinkle are well-known "Side B" Christian apologists, and Yarhouse and Zaporozhets mention in their acknowledgments their gratitude to Coles for helping to copyedit an early draft of the book. The McDonald's are the founders of the nonprofit "Embracing the Journey", named after their book, whose website lists several resources that promote committed same-sex relationships. They are "Side A" Christians who have supported "conversion therapy" bans (https://www.npr.org/2019/04/26/716416764/activists-and-suicide-prevention-groups-seek-bans-on-conversion-therapy-for-mino). "Side A" Christians believe same-sex sexual relationships between Christians can be biblical, while "Side B" Christians promote chastity among Christians struggling with same-sex attractions. Neither of these Sides see a place for interested same-sex attracted or gender dysphoric persons to explore childhood trauma or other developmental factors as potential contributing influences in their experience of sexuality and gender.

A final concern about *When Children Come Out* is the authors attempt to include the subject of transgenderism. Their treatment is too cursory to really be helpful. The authors would have been better off addressing transgenderism and its many unique and rapidly developing features in a separate text altogether. Parents, especially traditionally Christian ones, looking for help in this area will be better served by reading Grossman's *Lost in Trans Nation*, which I reviewed earlier in this journal.

In conclusion, although there is some good advice for parents in *When Children Come Out*, parents who are already committed to a historic Christian understanding of sexual ethics and ideals will need to read this book with significant discernment. Although it is a bit dated, such parents wanting sound guidance regarding a same-sex attracted child from a perspective clearly aligned with traditional faith will still want to be familiar with Dallas' *When Homosexuality Hits Home: What to Do When a Loved One Says They're Gay*. The challenges for parents navigating a child coming out are herculean, and professional and faith-based guidance varies greatly depending on the beliefs of the authors. For this reason alone,

Yarhouse and Zaporozhets' book should not be the sole resource parents consult in navigating these issues.

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