

Philip M. Sutton, PhD
International Federation for Therapeutic Choice (IFTC)

What the Research Does and Does Not Say:

**Is Therapeutic Support for Unwanted
Same-Sex Attractions Harmful?**

ENDORSEMENTS

“‘What the Research Does and Does Not Say ...’ should be required reading for mental health providers, physicians, client/patient advocates, legislative and judicial bodies involved in matters regarding human sexual identity. Science, beneficence, non-maleficence and informed consent, not propagandized soundbites, must serve as the foundation for all healthcare.”

Michelle A. Cretella, MD, Vice President, American College of Pediatricians, USA

“This booklet stands out due to its high degree of differentiation and objectivity. All those who are interested in knowing more about the issue of therapy for individuals with unwanted same-sex attraction will find Philip Sutton’s well-founded information extremely valuable.”

Dr. med. Christl R. Vonholdt, Physician, Paediatrician, Director German Institute for Youth and Society, Germany

“In this clear and succinct report, Dr Sutton explains why evidence of harm from Sexual Orientation Change Efforts (SOCE) is never produced upon request. International attempts to ridicule and ban such therapies today are not based on science but on gay-affirming ideology. This emperor has no clothes on.”

Dr Peter May MRCGP, United Kingdom

“Ideology is like delirium: it resists all evidence of the facts. But if someone is looking for facts about homosexuality, they will be found in abundance in this book”.

Roberto Marchesini, Psychologist and Psychotherapist, Italy

“Scientific integrity is being routinely compromised by mental health associations in order to advance a political and policy agenda. Dr Sutton is to be commended for concisely documenting this phenomenon. Without the cultivation of ideological diversity in the psychological disciplines, the truth regarding change in same-sex attractions and behaviors will continue to be obscured, with deleterious consequences for the development of responsible professional and public policy.”

Christopher H. Rosik, Ph.D., Licensed psychologist, current President of the Alliance for Therapeutic Choice and Scientific Integrity, APA member since 1984. USA

“The official attempts to prove that, at the roots of same-sex attraction, there is no psychological dimension which could be therapeutically explored and understood, seem to bear an element - however slight - of fearful eagerness. But neither Sigmund and Anna Freud, nor Alfred Adler, Karl Gustav Jung and many others later had any doubts of the value of such efforts. Dr Sutton’s research of this question remains faithful to the best tradition of friendly and objective truth in understanding matters of human suffering”.

Dr. Gintautas Vaitoska, psychiatrist, Director of Studies of Marriage and the Family Program at the International Theological Institute in Austria.

“Dr Sutton brings to the public’s attention how much scientific nonsense lies behind attempts to ban the treatment of people troubled by same-sex thoughts, feelings and behaviours. The false claims, and distortions by the media, need to be put aside so that competent, qualified therapists can respond to the wishes of people troubled in this way just as they would to any other problems that people bring them. Numerous solid studies have shown good results for many. The ‘banners’ deny such results, while repeatedly alleging ‘potential’ harm - without any valid supporting evidence that significant harm has actually taken place”.

Joseph Berger MBBS (Hons) FRCP(C) DABPN, Consulting Psychiatrist, Toronto, Canada

“Progress in science and humanity in the Western world has always depended on freedom of thinking and research. Today this freedom is

seriously threatened in the field of homosexuality by the imposition of the gay emancipation ideology by the State as if it were an infallible religious and moral doctrine. Alternative scientific insights and a vast body of facts are being repressed and constructive help for homosexually inclined people who do not want to live homosexually is tabooed. Yet groups of modern “dissidents”, academic psychologists, psychiatrists, and other professionals who cannot but reject the dubious dogmas of a politicized ideological trend that will certainly pass by, sooner or later, keep going the non-ideological research on the psychology of homosexuality as well as provide constructive support and counseling for those who choose not to commit themselves to the gay lifestyle (any more). This booklet defends what is worthwhile in the traditional thinking and treatment of homosexuality.”

Gerard J.M. van den Aardweg, Ph.D. Netherlands

Author of *Homosexuality and Hope, On the Origins and Treatment of Homosexuality, and, The Battle for Normality.*

I enjoyed Philip Sutton’s paper but was also shocked by it. As an epidemiologist, I am used to scientific discussions on the quality of evidence, study designs and bias and on how to critically understand any proposed conclusions. This is often difficult when commercial interests distort scientific evidence. Philip Sutton deals with ideological rather than commercial interests, explaining how professional associations may disregard scientific criteria and suggest SOCE should be banned. It is shocking that they base their prohibitions on descriptive studies (that should, by definition, never reach conclusions), with selection bias, misclassification of exposure and outcome and a problem of reverse causality.

Unfortunately, judges and politicians may be ill prepared to make these scientific judgments and may follow politically correct agendas. But adult and consenting clients have the right for their counseling choices to be available on the grounds of scientific evidence, not pseudo democratic choices. Science is not a matter for majority vote.

Jokin de Irala MD, MPH, PhD, University of Navarre, Spain

Co-author, *The use of expensive technologies instead of simple, sound and effective lifestyle interventions: a perpetual delusion* J Epidemiol Community Health 2014;68:9897-904

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FOREWORD

The British Establishment appears to have ended discussion on whether or not homosexuality is innate. Its new orthodoxy, complete with evangelists in every political party, will not engage in debate with the other side, in anything but a superficial way, because they feel there is no need to argue with bigotry and homophobia. This new cultural edifice, grounded in the “born gay” myth, (which the Royal College of Psychiatrists [April 2014¹] admits is inaccurate) must be protected at all costs; hence the mental health establishment’s effective ban on therapies referred to by the American Psychological Association (APA: 2009) as Sexual Orientation Change Efforts (SOCE). Such therapeutic work may be offered through a variety of modalities, may be analytical in approach, or may be primarily psychodynamic. Therapeutic modalities may range from essentially “talking therapies” such as Cognitive Behavioural Therapy (CBT), to “action therapies” including Psychodrama or Drama Therapy. They may be eclectic in approach, or focus more on cognition or on the emotions (affect). They are well accepted and widely used to help clients in a variety of contexts – with the single exception of those who wish to reduce same-sex attraction.

There are parallels between this movement and what Sean Collins² wrote recently about Same Sex marriage:

In addition to quashing dissent, what makes the gay-marriage campaign a dark kind of Cultural Revolution is its white-washing and distortion of history. SSM advocates face an obstacle in their attempt to make ‘traditional marriage equals bigotry’ an unquestioned dogma: it flies in the face of the historical record and experience. It was not so long ago that many reasonable people espoused a conventional view of marriage, and in no way could they be said to be animated by

1 http://www.rcpsych.ac.uk/pdf/PS02_2014.pdf

2 http://www.spiked-online.com/newsite/article/Gay_marriages_echoes_of_the_Cultural_Revolution/13760#.UwXK1c5S668

hatred towards gays. And so today's gay-marriage campaigners are forced, like Maoists of the past, to rewrite history to have it conform with today's new party line.

Geraint Davies' Private Member's ***Counsellors and Psychotherapists (Regulation) Bill 2014*** may have passed unnoticed into the parliamentary "soup", but rumour has it that it will reappear in future election manifestos. Medical and mental health history is being re-written. A consistent witness starting with Freud both Sigmund and Anna, Irving and Toby Beiber, Lawrence Hatterer, Charles Socarides *et al*, is increasingly air-brushed from history. Professor Michael King continues to perpetuate the idea that in contrast with gay affirming therapies, no credible evidence exists to support the use of SOCE therapies. The Royal College of Psychiatrists, espousing King's views, leads the way and the UK Council for Psychotherapy (UKCP), British Association for Counselling and Psychotherapy (BACP) and of late even the Association of Christian Counsellors, follow on a "me too" basis. The college supports the recent publication (February 2014) of the UKCP-led "Conversion Therapy Consensus Statement"³: the clearest evidence yet of UK mental health professional bodies collaborating with campaigning organisations (Stonewall Ltd) and private providers of "Gay affirming Therapy" - 'Pink Therapy' Ltd. None of these organisations objected to Davies' illiberal proposal to ban therapeutic support for unwanted same-sex attractions and behaviours - having already effectively achieved the same end themselves by denying access to training and supervision to any therapist who holds the view that homosexuality may respond to therapeutic efforts to reduce or eliminate it.

The march of gay marriage across the USA is instructive in showing the spread of this ideology, by stealth. Observe: 2004 was a good year for American voters opposing the redefinition of marriage. Fifty-seven percent of Virginians, 76% of Oklahomans, 66% of voters in Utah and 75% in Kentucky voted to amend their state's constitution

³ http://www.psychotherapy.org.uk/UKCP_Documents/policy/Conversion%20therapy.pdf

so as to define marriage as the union between a man and a woman. Every one of those amendments has now been overturned by District Judges who Denis Prager (2014)⁴ says “have a hubris that is simply breathtaking”. In striking down the 1996 Defense of Marriage Act (DOMA), they say that the only motive for that act was a ‘bare... desire to harm a politically unpopular group’, thus this Congressional Act was based on irrational hostility to gays, nothing more.

Core Issues Trust has more than once requested the most powerful Mental Health Bodies in the UK, the Royal College of Psychiatrists and the UK Council for Psychotherapy to identify peer-reviewed studies that showed that SOCE practices are harmful to clients on average. But they simply will not debate the issue.

We are still hoping that this information will be forthcoming.

We seek genuine debate around the issue of “harm” in relation to therapeutic support for sexual orientation change efforts, whether these be with a view to management, reduction or elimination of unwanted same-sex attractions and behaviours. In the belief that even those who remain sceptical of change efforts are in favour of scientific debate and therapeutic choice as a foundational principle of mental health support, I commend to your reading this paper by Dr Philip Sutton of the International Federation for Therapeutic Choice.

Mike Davidson, PhD., FHEA.

Director,

Core Issues Trust.

www.core-issues.org

⁴ 18 February, 2014 <http://townhall.com/columnists/dennisprager/2014/02/18/judges-hubris-and-samesex-marriage-n1796339/page/full> <accessed 20 February, 2014>

PREFACE

Dr Philip Sutton has provided eight discussion points which contribute to the debate on whether or not therapeutic support for unwanted same-sex attractions may be harmful. This paper should be a welcome contribution, irrespective of a reader's position on the subject, because it contributes to a debate that has not been allowed to take place in the UK.

The recognition of SOCE (in the plural) as a field with many perspectives offering multiple modalities rather than a singular approach, is important. Referred to pejoratively as "Reparative" or "Conversion" therapy, SOCE have not been properly engaged with by professional mental health bodies in the UK. Researchers have not found a single therapeutic modality which has been shown, on average, to cause harm, except for discredited aversion therapies.

Current political pressure in the UK does not seek to ban particular modalities per se, for this would lead to the cessation of a vast amount of therapeutic work whose positive value is well established. Rather it proposes to ban any and all modalities when, and only when, they are intended to lead to a particular result desired by the client – the reduction of same-sex attractions. By so doing, and by ignoring the possibility of improving current approaches, and still further, the likelihood that entirely new approaches might be developed in the future, people's rights are being closed down by professionals who will not recognise, in this one instance, a client's right of choice.

Those who engage in discussion around this issue would do well to remember that it was the professional mental health organisations themselves who sanctioned the electro-shock and chemical aversion therapy approaches that have long since been abandoned but are regularly hinted at in the present context, as though today's SOCE were in some way comparable. From that historical extreme, society now appears to be considering another: the banning through legislation of the right of choice of, for example, a married man wanting to reduce and where possible eliminate homosexual desires because he values his opposite-sex marriage and wishes to change his sense of sexual identity, feelings and expression. The claim that this is impossible is a controversial one, steeped in the myth that homosexual feelings are innately inherent.

Core Issues Trust has asked some of the major mental health bodies in the UK to identify any studies showing that change is impossible, and that to offer therapeutic support or SOCE, is intrinsically harmful. I have personally written to Mr David Pink, CEO of the UK Council for Psychotherapy, and co-authored a letter to Professor Sue Bailey, President of the Royal College of Psychiatrists. Both have declined to answer such requests. The Association of Christian Counsellors, taking a stand along with all secular mental health providers of training in the UK, is choosing simply to fall in line, avoiding the hard work of looking at the scientific evidence and research literature.

The reader needs to take care to assess this issue not in terms of ideology but rather in the light of objective scientific data. Once the light bulb of science is shattered, the resulting darkness will benefit nobody. The arguments of Philip Sutton and the International Federation for Therapeutic Choice, under the National Association for Research and Therapy of Homosexuality (NARTH) deserve to be heard, and to be engaged with.

Dermot O'Callaghan MA (Cantab)

Co-author, Out of Harm's Way, Core Issues Trust (2013).

About the Author

Philip Sutton earned a BA from the University of Notre Dame and both an M.S. and Ph.D. from Purdue University.

He is a licensed psychologist in the states of Michigan and Ohio, and a licensed marriage and family therapist and licensed clinical social worker in the state of Indiana. He is a member of the (State of) Michigan Psychological Association, and a clinical partner (member) of the Alliance for Therapeutic Choice and Scientific Integrity. Dr Sutton serves as the Editor of the Alliance's Journal of Human Sexuality and as Director of the Alliance's International Federation for Therapeutic Choice (IFTC).

Philip Sutton is also an associate member of the Catholic Medical Association, as well as a member of the Fellowship of Catholic Scholars and of the Society for Catholic Social Scientists

What Research Does and Does Not Say about the Possibility of Experiencing “Harm” by Persons Who Receive Therapeutic Support for Unwanted Same-Sex Attractions or “Sexual Orientation Change Efforts (SOCE)”⁵

Philip M. Sutton, Ph.D.

Director, International Federation for Therapeutic Choice

Abstract

In recent years, national and international medical and mental health associations typically have emphasized the potential harmfulness of professional care for unwanted same-sex attraction and behavior (SSA or homosexuality). During 2012 and 2013, state legislatures in the U.S. and legislative bodies in other countries either have passed or are considering passing laws which would penalize professionals who provided professional care for unwanted SSA – to minors and/or adults – the loss of the license to practice. This paper was written as a response to the present situation in the United Kingdom. The paper reviews the universal ethics of all medical and mental health professionals to avoid harm and do good (non-maleficence/malfeasance and beneficence); discusses the documented potential for harm when using *every* mental health treatment for *every* presenting problem; clarifies steps taken by the *Alliance for Therapeutic Choice and Scientific Integrity (ATCSI)* and its international division, the *International Federation for Therapeutic Choice (IFTC)*, to promote ethical professional care for unwanted SSA; clarifies the injustice and presumed ideological biases of the medical and mental health associations’ warning about the potential for harm for psychotherapy only for unwanted SSA and not all approaches; and documents that the research purporting to show this harmfulness, in the research authors’ own words, does not do so. Recommendations to promote scientific integrity in the conduct and reporting of relevant research are offered.

5 A version of this document was published in February, 2014 by Core Issues Trust. Retrieve from <http://www.core-issues.org/uploads/IFTC%20Sutton%20Paper%2021%20Feb%202014.pdf>. A version of this document also has been accepted for publication by *Linacre Quarterly*.

INTRODUCTION

It has come to the attention of the International Federation for Therapeutic Choice (IFTC) that the UK Parliament will soon be debating the merits of the proposed Private Member's Bill ***Counsellors and Psychotherapists (Regulation) Bill no. 14120***, (<http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0120/14120.pdf>) which would amend ***Section 60 of the Health Act 1999 (Regulation of health care and associated professions)*** as follows: ***"The [Code of ethics for registered counsellors, therapists and psychotherapists]*** must include a prohibition on gay to straight conversion therapy." The ***Complaints and disciplinary procedures of the Code*** would be amended as follows: "(2) A practitioner found by the Council to have breached ... that section of the code relating to prohibition of gay to straight conversion therapy shall result in permanent removal from the register."

This information came to our attention when reading a professional statement by the United Kingdom's Association of Christian Counsellors (ACC, 2014) and a news report of this statement in *The Guardian* (Strudwick, 13 January 2014). Both the ACC statement and Guardian report made serious allegations about the great risk for "harm" to persons who receive "reparative or conversion therapy," what the American Psychological Association (APA) has chosen to call "Sexual Orientation Change Efforts (SOCE)" (APA, 2009).

Members of the IFTC (www.therapeutic-choice.org/) and the IFTC's parent organization, the ***Alliance for Therapeutic Choice and Scientific Integrity (ATCSI)***; (www.therapeuticchoice.com) and like-minded licensed medical and mental health professionals, refer to such therapy as licensed professional care to "change" - i.e., manage, diminish or resolve - unwanted same-sex attractions (SSA) and behavior. Such professional care may include educational guidance, counseling, therapy and/or medical services.

Specifically, the ACC statement declared: "we do not endorse Reparative or Conversion Therapy" because of "the potential to create harm" and "in the interests of public safety." The report in *The Guardian* commented:

Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder ... found 'conversion therapy' *usually* led to worsened mental health, self-harm and suicide attempts...such treatment *routinely* led to worsened (sic) self-harm, thoughts of suicide and suicide attempts (emphasis added).⁶

The ACC statement and Guardian story reflect the views of four leading mental and medical health professional associations in the UK. The British Medical Association (2010) voted at its Annual Representative Meeting that "'conversion therapy' for homosexuality... is discredited and harmful to those 'treated'." The British Association for Counselling and Psychotherapy (2013) mentions the PAHO/WHO (2012) position statement that practices "such as conversion or reparative therapies...represent a severe threat to the health and human rights of the affected persons" (p.i).

Similarly, the Royal College of Psychiatrists (n.d.) states that "we know from historical evidence that treatments to change sexual orientation that were common in the 1960s and 1970s were very damaging" and specifically mentions that the 2002 "Shidlow (sic) and Schroeder" study showed that such treatment resulted in "considerable harm." And the UK Council for Psychotherapy (2010) asserts that a person who undergoes "therapy that aims to change or reduce same sex attraction" is at risk for "considerable emotional and psychological cost."

These and other recent **allegations that the harmfulness of "SOCE" has been proven scientifically are simply false** (Rosik, 2013a, 2013b, 2013c, 2013d, 2013e). Warnings by national mental health associations of the "potential harmfulness of 'SOCE'" are unscientific, professionally irresponsible, and misleading, if not dishonest.⁷ These observations are explained below.

⁶ This report was retrieved on 15 January 2014. When attempting to retrieve this report again on 6 February 2014, the link no longer worked. Instead, a report by the same name was retrieved from <http://www.theguardian.com/world/2014/jan/13/christian-therapists-stop-conversion-therapy-turn-gay-patients-straight>. In this revised *Guardian* report, the claims of "harm" due to "conversion therapy" are described as follows: "Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder has shown such treatment routinely led to worsened mental health, self-harm, thoughts of suicide and suicide attempts."

⁷ The IFTC (2011, 2012, 2013) has offered interventions at the Organization for Security and Co-operation in Europe (OSCE) Office of Democratic Institutions and Human Rights (ODIHR) Human Dimension Implementation Meeting (HDIM) in Warsaw, Poland on these and related concerns.

1. First, do no harm. Then do as much good as you can.

Avoiding and minimizing harm (nonmaleficence, nonmalfeasance) and doing good for those one serves (beneficence) are the foundational principles of ethical care by all mental - and medical - health care professionals. As an illustration, the first Principle of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010) states:

Principle A: Beneficence and Nonmaleficence: Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons

2. Every approach to medical and mental health care has the potential for harmful - or at least unwanted - side effects. And no approach is guaranteed to work for any particular patient or client, even if "taken or used as directed."

Lambert (2013) reports that reviews "of the large body of psychotherapy research, whether it concerns broad summaries of the field or outcomes of specific disorders and specific treatments" lead to the conclusion that, while all clients do not report or show benefits, "psychotherapy has proven to be highly effective" for many clients (p. 176). Unfortunately, the research "literature on negative effects" also offers "substantial...evidence that psychotherapy can and does harm a portion of those it is intended to help." These include "the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment" (p. 192). Such findings have been reported in the therapeutic and scientific communities for over three decades (Lambert, 2013; Lambert & Ogles, 2004; Lambert & Bergin, 1994; Lambert, Bergin and Collins, 1977; Lambert, Shapiro & Bergin, 1986; Nelson, Warren, Gleave, & Burlingame, 2013; Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010). As Rosik (2013c) has written,

Any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general. Deterioration rates would need to be established for professionally conducted change-oriented therapy ("SOCE") significantly beyond 10% for adults and 20% for youth in order for

claims of approach-specific harms to be substantiated.

In this light, it is unfortunate that the UK Association of Christian Counsellors (2014) has the following ethical guideline for membership: # 5.5. “*Members should avoid any action which might cause harm to a client.*” If any - and every - action that *may* occur in counseling “*might* cause harm to a client,” how does the ACC envision any of its counselors ever attempting to serve their clients? Their position is not science but wishful thinking. As Rosik (2013e) has noted:

Reasonable clinicians and mental-health association representatives should agree that anecdotal accounts of harm constitute no basis upon which to prohibit a form of psychological care. If this were not the case, the practice of any form of psychotherapy could place the practitioner at risk of regulatory discipline, as research indicates that 5 to 10% of all psychotherapy clients report deterioration and as many as 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

3. The IFTC and ATCSI have taken steps to minimize the potential harmfulness and enhance the potential helpfulness of professional care for unwanted SSA through the *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior* (NARTH, 2010). (See Appendix A - below - for the short form of the *Practice Guidelines*.)

These *Practice Guidelines* were formally adopted in 2008 and published in 2010. Their purpose is to guide the ethical practice of “change-oriented” professional mental and mental health care for unwanted SSA. The *Practice Guidelines* have been written, published and used to educate medical and mental health professionals – as well as concerned nonprofessionals – about how to enhance the helpfulness and avoid any harmfulness of providing professional care for unwanted SSA.

For example, ***Practice Guideline # 5*** advises: “*At the outset of treatment, clinicians are encouraged to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent.*”

Concerning potential harmfulness, ***Practice Guideline # 6*** states:

“Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.”

As many of the “therapists” who reportedly provided “conversion therapy” to persons interviewed by Shidlo and Schroeder (2002) were not professionally trained or licensed (see Point 5 below), ***Practice Guideline # 11*** is especially relevant: ***“Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area.”***

Translations of the short form of the *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior* are available, so far, in Chinese, French, German, Italian, Polish, Russian, and Spanish. Translations of the long form are available in Polish and Spanish, as well. These translations may be retrieved from <http://www.narth.com/#!about3/c1k2y>

4. “There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom” (American Psychological Association, 2009, p. 83). In the same document, the APA states further: “None of the recent research...meets methodological standards that permit conclusions regarding efficacy or safety (APA, 2009, p. 2.) APA similarly emphasizes that “recent SOCE research cannot provide conclusions regarding efficacy or safety” (p. 3). The APA offered these conclusions *after* having reviewed all relevant research to date, including the study by Shidlo and Schroeder (2002).

5. In the authors’ own words, the Shidlo and Schroeder (2002) study does “not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy” (p.249), i.e., “SOCE”.

Shidlo and Schroeder acknowledge that *how* they conducted their study limits what any reports of “harm” given by the participants in their study may mean. The authors accurately describe their research as an “exploratory study...based on the retrospective accounts of consumers” who are asked to talk about what their therapists did and what the consumers experienced “on average ... 12 years ago” (p. 250). The authors acknowledge that, like all research using this

method, the reports of the alleged consumers' perspectives on their experience of therapy "may not accurately reflect" what actually happened. Shidlo and Schroeder discuss the potential limitations of the accuracy of the reports of their consumers, in light of the earlier findings of Rhodes, Hill, Thompson, and Elliott (1994) that "retrospective data from clients" are subject to "misunderstandings" about what happened years earlier in psychotherapy. As actual former clients try to make sense of the events of their experience of therapy, they may unknowingly change the details of their story (Rhodes, et al., p. 481).

Additional problems with how the Shidlo and Schroeder study was conducted further erode the scientific credibility and significance of any of its results.

- › Initial participants of the study were recruited with the following advertisement:

Have you gone through counseling or therapy where you were encouraged to become heterosexual or ex-gay? The National Lesbian and Gay Health Association wants to hear from you. The organization is conducting research for a project entitled "Homophobic Therapies: Documenting the Damage." (Shidlo & Schroeder, 2002, Appendix A)

Such a recruitment statement is an example of research based more on ideology than on objective, scientific inquiry.

- › There is **no** evidence - **besides** the interviewees' claims - that:
 - » They **actually participated** in a "conversion therapy" ("SOCE").
 - » They **actually experienced** the harms they claimed to have.
 - » Any actual harm did not preexist their experience of "conversion therapy" ("SOCE").
 - » Any actual harm occurred **as a result of, during or after**, the sessions of "SOCE," instead of as a result of an experience outside of "therapy."
- › While approximately two-thirds of the "therapists" reported by the presumed former clients were described as "licensed mental health practitioners," one third of the "therapists" were

“unlicensed counselors,” including “peer counselors, religious counselors, and unlicensed therapists.” Shidlo and Schroeder did not clarify what kinds of “harm” were associated with which kind of therapist. This study does not – and cannot based on how it was designed and conducted – show that, if consumers were harmed, this resulted from the actions of licensed mental health professionals who provided “conversion therapy” (i.e., professional “SOCE”) vs. nonprofessional caregivers.

- › Ironically, a careful reading of the report of this study, which admittedly was intended to “document the harm” experienced by consumers of “SOCE,” also showed the opposite result. In particular, the results suggest that pre-existing suicidality was at least managed, not induced by the participants’ experience of “SOCE” (Whitehead, 2010, pp. 161-165).
- › Several studies published during the past two years which also were intended to document the harm of receiving such professional care suffer from the same methodological difficulties as the Shidlo and Schroeder (2002) study and offer no better evidence in support of the harmfulness claim (Rosik, 2014).

6. Medical and mental health professionals, and their patients and clients, would not allow the kind of “evidence” provided by the Shidlo and Schroeder (2002) study to prevent them from receiving wanted treatment for any other concern.

Imagine how someone who has experienced a helpful medical or mental health-care product or service would feel, if their product or service were forbidden them based on the kind of information provided by the Shidlo and Schroeder (2002) study. Otherwise satisfied customers would be refused the chance to continue – and willing new consumers to start – receiving these products for services based on complaints – but no clear evidence – of harmful side effects. Those complaining would not have to prove that they actually received the products or treatment – or that they had used them as directed. The complainers would not have to prove that they actually experienced the side effects they claimed, or that the side effects did not already exist prior to their treatment. Nor, would complainers have to prove who they received the product or service from, while admitting that some of the care providers were professionally licensed, but as many as a third were not.

Most people would not accept their favourite pain reliever or medical treatment being taken off the market based on such minimal “evidence.” Retrospective (“anecdotal”) reports – based on what allegedly happened an average of 12 years ago – are not an acceptable standard of “evidence” for stopping or preventing others from receiving care which *has* been found helpful – by some. The various professional organizations which are so quick to accept the truthfulness of any complaints about the harmfulness of “SOCE” are also too quick to deny the validity of over a century of professional reports which document wanted changes in same-sex attraction and behavior (APA, 2009; NARTH, 2009; Phelan, 2014).

As a rule, IFTC, ATCSI and allied mental health professionals do *not* attempt to “cure” same-sex attractions and behaviors. Rather, we agree that change in sexual orientation is not typically categorical in nature and observe that clients may experience changes on a continuum that is personally meaningful and satisfying (NARTH, 2012). While not agreeing that “SOCE” is or may be beneficial, even the APA (2009) admits that “the recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid” (p. 14, cf. p. 2). Fluidity in sexuality, sexual orientation, sexual orientation identity, and relationships – without professional assistance – seems especially true among adolescents (p. 76) and women (p. 63; cf. Diamond, 2009), and has been documented as occurring among men as well (Laumann, et al., 1994).

7. There is a violation of some clients’ right to “self-determination” and a potential for harm, for not offering – let alone forbidding – professional care for unwanted SSA (“SOCE”) to persons who freely choose to seek such care.

Another foundation for ethical, beneficial practice is respect for clients’ and patients’ right to “self-determination.” As *Principle E: Respect for People’s Rights and Dignity* of the APA (2010) Ethical Principles states: “Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and *self-determination*” (emphasis added). Surely, this must include the rights of persons to choose to manage or resolve same-sex attractions and behaviors.

Also, there would be appear to be the potential for grave harm caused to some people by neglecting to provide such care for those who want it. There are significant medical and psychological health risks which co-occur with engaging in same-sex behavior (CDC, 2014; NARTH, 2009, III. Response to APA Claim: There Is No Greater Pathology in the Homosexual Population than in the General Population, p. 53-87; Whitehead, 2010).

Anecdotal and correlational studies clearly document that sexual abuse and other emotionally traumatic events are more common in the childhoods of persons with sexual minority attractions and behaviors than those with heterosexual (Austin et al., 2008; Corliss, Cochran, & Mays, 2002; Friedman et al., 2011; Lehavot, Molina, & Simoni, 2012; Stoddard, Dibble, & Fineman, 2009; Steed & Templer, 2010; Tomeo, Templer, Anderson, & Kotler, 2001; Wells, Magnus, McGee, & Beautrais, 2011). Sexual abuse in particular has been shown to precede the development of Gender nonconformity (Alanko, et al., 2008; Roberts, Glymour, & Koenen, 2103) as well as of same-sex attractions and behavior for some persons (Fields, Malebranche, & Feist-Price, 2008; Walker, Archer, and Davies, 2005).

While further research is needed to clarify the extent of any causal connection between traumatic childhood events and the development of SSA and behavior, their co-occurrence is undeniable. Professional compassion warrants assisting those who want to try to manage and resolve SSA behaviors – and the underlying feelings and experiences which may motivate them.

8. Moving forward, it is necessary that national and world medical and mental health associations deal with the issue of therapeutic choice concerning unwanted same-sex attraction in a professionally responsible manner with scientific integrity.

Persistent warnings that professional “SOCE” have “the potential to harm” those who receive them are misleading and disserve the general public. Organizations like the American Psychological Association, The World Medical Association, and - most recently - the Association of Christian Counsellors in the UK, in effect deceive the public when they – not inaccurately – warn that there is a *potential* for harm, but then do not qualify this warning by clarifying that (1) *all* mental health services for all personal and interpersonal concerns have this risk *and* (2) that responsible science has not yet shown

whether the degree of risk for professional “SOCE” is greater, the same as, or less than the risk for all other psychotherapies.

Overall, we agree with Shidlo and Schroeder (2002) that more **“complementary research (is) needed.”** Such research ideally **“would include interviews with sexual orientation conversion therapists and analysis of psychotherapy sessions by independent third-party observers.”** In the absence of such clear, reliable and valid scientific evidence, it is difficult to avoid the conclusion that professional organizations like the American Psychological Association, the UK Association of Christian Counselors, various state and national government legislatures, and even media such as *The Guardian*, are working to prevent mental health professionals from offering educational-guidance, counseling and therapeutic care for persons with unwanted same-sex attraction and behavior based on ideological and not scientific or professional grounds. Persons who experience unwanted same-sex attractions and behaviors deserve the right to receive professional care to try to change (i.e., manage, diminish or resolve) these feelings and actions if they choose to do so.

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Appendix A:

Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behaviors

In December, 2008, at its annual strategic planning meeting, the National Association for Research and Therapy of Homosexuality (NARTH)'s Board of Directors formally accepted the following ***Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behaviors***. Their purpose is to educate and guide mental health professionals, who affirm the right of clients to pursue change of unwanted same-sex (homosexual) attraction and behavior (SSA), so that these professionals may provide competent, ethical, and effective guidance and care to those who seek it.

The goals of the *Practice Guidelines* are twofold: (1) to promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who seek change-oriented intervention for unwanted same-sex attractions and behavior, and (2) to provide information that corrects stereotypes or mischaracterizations of change-oriented intervention and those who seek it. These guidelines reflect the state of the art in the practice of guidance and psychotherapy with same-sex-attracted clients who want to decrease homosexual functioning and/or increase heterosexual functioning.

NARTH's Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior

Attitudes Toward Clients Who Seek Change

Guideline 1. Clinicians are encouraged to recognize the complexity and limitations in understanding the etiology of same-sex attractions.

Guideline 2. Clinicians are encouraged to understand how their values, attitudes, and knowledge about homosexuality affect their assessment of and intervention with clients who present with unwanted same-sex attractions and behavior.

Guideline 3. Clinicians are encouraged to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing change-oriented

interventions.

Guideline 4. Clinicians are encouraged to respect the dignity and self-determination of all their clients, including those who seek to change unwanted same-sex attractions and behavior.

Treatment Considerations

Guideline 5. At the outset of treatment, clinicians are encouraged to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent.

Guideline 6. Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.

Guideline 7. Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions that often accompany same-sex attractions and to offer or refer clients for relevant treatment services to help clients manage these issues.

Guideline 8. Clinicians are encouraged to consider and understand the difficult pressures from culture, religion, and family that are confronted by clients with unwanted same-sex attractions.

Guideline 9. Clinicians are encouraged to recognize the special difficulties and risks that exist for youth who experience same-sex attractions.

Education

Guideline 10. Clinicians are encouraged to make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religious resources that can support clients in their pursuit of change.

Guideline 11. Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area.

As do all professional guidelines, the preceding *Practice Guidelines* were written in order to supplement accepted principles of

psychotherapy, not to replace them. As *guidelines*, they are aspirational and intended to facilitate the continued, systematic development of the profession and to help assure a high level of professional practice by clinicians.

The clinical and scientific research which supports each of the *Practice Guidelines* is explained in detail in Volume 2 of NARTH's ***Journal of Human Sexuality (JHS)***. A copy of JHS Volume 2 may be retrieved from <http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2> and the complete ***Practice Guidelines*** may be retrieved from <http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines>. Translations of the short form of the ***Practice Guidelines (Guidelines)*** only without explanation) are available, so far, in Chinese, French, German, Italian, Polish, Russian, and Spanish. These translations may be retrieved from <http://www.narth.com/#!about3/clk2y>

