SB 1172 (Lieu) – Sexual Orientation Change Efforts

Introduced February 22, 2012, Chaptered September 30, 2012

This bill prohibits a mental health provider from engaging in sexual orientation change efforts with a patient under 18 years of age, regardless of the willingness of a patient, patient's parent, guardian, conservator, or other person to authorize such efforts.

According to the author's office, the intent of this bill is to limit deceptive therapies that are harmful to minors by mental health providers. This bill seeks to provide awareness of the alternatives to and the potential harmful effects of sexual orientation change therapies while also protecting children from these treatments. The author states "this so-called reparative therapy, conversion therapy or reorientation therapy is scientifically ineffective and has resulted in much harm." This bill seeks to provide protections for lesbian, gay, bisexual, and transgender youth by preventing these types of therapies that are potentially dangerous as well as making adults aware of the potential harms associated with sexual orientation change therapies.

Specifically, this bill:

1. Defines "mental health provider" as a physician and surgeon specializing in the practice of psychiatry, a psychologist, a psychological assistant, a licensed marriage and family therapist, a registered marriage and family therapist, intern, or trainee, an educational psychologist, a licensed clinical social worker, an associate clinical social worker, a licensed professional clinical counselor, or a registered clinical counselor, intern, or trainee.

2. Defines "sexual orientation change efforts" as practices by mental health providers that seek to change orientation or reduce or eliminate sexual or romantic attractions, feelings, or behaviors because those attractions, feelings, or behaviors are directed toward persons of a particular sex or both sexes.

3. Specifies "sexual orientation change efforts" does not include psychotherapies that aim to provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, without seeking to change orientation or reduce or eliminate sexual or romantic attractions, feelings, or behaviors because those attractions, feelings, or behaviors are directed toward persons of a particular sex or both sexes.

4. Specifies that under no circumstances shall a mental health provider engaged in sexual orientation change efforts with a patient under 18 years of age, regardless of the willingness of a patient, patient's parent, guardian, conservator, or other person to authorize such efforts.

5. Provides that any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider shall be considered unprofessional conduct and shall subject the provider to discipline by the provider's licensing entity.

6. Provides findings and declarations of the Legislature including that being lesbian, gay or bisexual is not a disease, and that sexual orientation change efforts can pose critical health risks, as described.

7. Provides statements of psychological, psychiatric, medical, and other associations' regarding their disproval of therapy aimed at changing sexual orientation or therapy based on the assumption that homosexuality is a mental disorder.

8. States that California has a compelling interest in protecting the lives and health of lesbian, gay, and bisexual people.

History of Homosexuality and the American Psychiatric Association (APA). A number of research studies on homosexuality conducted in the 1940s and 1950s, combined with protests during the civil rights movement of the 1960s and 1970s led to the reformation of how homosexuality was classified by mental health and medical associations such as the APA and the APA removed homosexuality from its official Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973.

Prior to the civil rights movement, the medical view of homosexuality was that it was a mental disorder and disease. There were a series of resulting encounters between activists and psychiatrists at the annual meetings of the APA between 1970 and 1972 where gay activists challenged the APA. As a result, the diagnosis of homosexuality was deleted from the DSM-II.

The APA did not initially embrace this change. In recognition of those who opposed deleting the classification, the APA made a compromise. The DSM-II diagnosis of Sexual Orientation Disturbance replaced homosexuality. Accordingly, individuals comfortable with their homosexuality were no longer classified as having a mental disorder. Instead, only those who were "in conflict with" their sexual orientation were classified as having a mental disorder. However, this change engendered continued controversy. Those opposing the diagnosis argued that there were no reported cases of unhappy heterosexual individuals seeking treatment to become homosexual. This problem was addressed in the 1980s DSM-III where Sexual Orientation Disturbance was replaced by ego-dystonic homosexuality (EDH).

In the mid-1980s during the revision of the DSM-III, the diagnosis of EDH also engendered controversy. Those on the APA Advisory Committee working on the revision who desired to retain the EDH diagnosis argued that they believed the diagnosis was clinically useful and that is was necessary for research and statistical purposes. The opponents noted that making a patient's subjective experience of their own homosexuality the determining factor of their illness was not consistent with the new evidence-based approach that psychiatry had embraced. They argued that empirical data did not support the diagnosis and that it was inappropriate to label culturally induced homophobia as a mental disorder. The APA Committee agreed with the opponents and the diagnosis of EDH was removed from DSM-III-R in 1987.

History of Homosexuality and the World Health Organization (WHO) . In 1992, WHO removed the diagnosis of homosexuality as a mental disorder from the International Classification of Disorders-10 (ICD-10). Similar to the DSM, the ICD-10 is a classification system for medical and mental disorders used internationally. WHO replaced homosexuality with the diagnosis of ego-dystonic sexual orientation which falls under the category of "Psychological and behavioral disorders associated with sexual development and orientation". The ICD-10 ego-dystonic sexual orientation diagnosis is defined as "The gender identity or sexual preference (heterosexual, homosexual, bisexual, or pre-pubertal) is not in doubt, but the individual wishes it were different because of associated psychological and behavioral disorders, and may seek treatment in order to change it."

WHO also notes: "Sexual orientation by itself is not to be regarded as a disorder? it is often a result of unfavorable and intolerant attitudes of the society or a conflict between sexual urges and religious belief systems."

Sexual Orientation Change Therapy. Sexual Orientation Change Therapy, sometimes called reparative therapy, conversion therapy, or reorientation therapy, is an attempt to change the sexual orientation of a person from homosexual or bisexual to heterosexual. According to the APA conversion therapy is a type of psychiatric treatment "based upon the assumption that homosexuality is a mental disorder or based upon the assumption that a patient should change his/her homosexual orientation."

Joseph Nicolosi, one of the founders of modern reparative therapy, promotes psychoanalytic theories suggesting that homosexuality is a form of arrested psychosexual development, resulting from "an incomplete bond and resultant identification with the same-sex parent, which is then symbolically repaired in psychotherapy." Nicolosi's intervention plans involve conditioning a man to a traditional masculine gender role via participation in sports activities, avoidance of the other sex unless for romantic contact, avoiding contact with homosexuals, increasing time spent with heterosexuals, engaging in group therapy, marrying a person of the opposite sex and fathering children.

Others, particularly conservative Christian transformational ministries, use the term conversion therapy to refer to the utilization of prayer, religious conversion, individual and group counseling to change a person's sexual orientation.

The federal Ninth Circuit Court of Appeals addressed the issue of sexual orientation therapy in the context of an asylum application. The court held that a Russian citizen who was subjected to sexual orientation change treatments that included sedative drugs and hypnosis "constituted mental and physical torture." (Pitcherskaia v. INS 118 F.3d 641 (9th Cir. 1997))

Senate Bill No. 1172

CHAPTER 835

An act to add Article 15 (commencing with Section 865) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 30, 2012. Filed with Secretary of State September 30, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1172, Lieu. Sexual orientation change efforts.

Existing law provides for licensing and regulation of various professions in the healing arts, including physicians and surgeons, psychologists, marriage and family therapists, educational psychologists, clinical social workers, and licensed professional clinical counselors.

This bill would prohibit a mental health provider, as defined, from engaging in sexual orientation change efforts, as defined, with a patient under 18 years of age. The bill would provide that any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider shall be considered unprofessional conduct and shall subject the provider to discipline by the provider's licensing entity.

The bill would also declare the intent of the Legislature in this regard.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Being lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming. The major professional associations of mental health practitioners and researchers in the United States have recognized this fact for nearly 40 years.

(b) The American Psychological Association convened a Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The task force conducted a systematic review of peer-reviewed journal literature on sexual orientation change efforts, and issued a report in 2009. The task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources.

(c) The American Psychological Association issued a resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in 2009, which states: "[T]he [American Psychological Association] advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth."

(d) The American Psychiatric Association published a position statement in March of 2000 in which it stated:

"Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

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

(e) The American School Counselor Association's position statement on professional school counselors and lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth states: "It is not the role of the professional school counselor to attempt to change a student's sexual orientation/gender identity but instead to provide support to LGBTQ students to promote student achievement and personal well-being. Recognizing that sexual orientation is not an illness and does not require treatment, professional school counselors may provide individual student planning or responsive services to LGBTQ students to promote self-acceptance, deal with social acceptance, understand issues related to coming out, including issues that families may face when a student goes through this process and identify appropriate community resources."

(f) The American Academy of Pediatrics in 1993 published an article in its journal, Pediatrics, stating: "Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."

(g) The American Medical Association Council on Scientific Affairs prepared a report in 1994 in which it stated: "Aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it."

(h) The National Association of Social Workers prepared a 1997 policy statement in which it stated: "Social stigmatization of lesbian, gay and bisexual people is widespread and is a primary motivating factor in leading some people to seek sexual orientation changes. Sexual orientation conversion therapies assume that homosexual orientation is both pathological and freely chosen. No data demonstrates that reparative or conversion therapies are effective, and, in fact, they may be harmful."

(i) The American Counseling Association Governing Council issued a position statement in April of 1999, and in it the council states: "We oppose 'the promotion of "reparative therapy" as a "cure" for individuals who are homosexual.'"

(j) The American Psychoanalytic Association issued a position statement in June 2012 on attempts to change sexual orientation, gender, identity, or gender expression, and in it the association states: "As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes."

(k) The American Academy of Child and Adolescent Psychiatry in 2012 published an article in its journal, Journal of the American Academy of Child and Adolescent Psychiatry, stating: "Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful. There is no empirical evidence adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness and caring, important protective factors against suicidal ideation and attempts. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial or necessary, and the

possibility that they carry the risk of significant harm, such interventions are contraindicated."

(*l*) The Pan American Health Organization, a regional office of the World Health Organization, issued a statement in May of 2012 and in it the organization states: "These supposed conversion therapies constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements." The organization also noted that reparative therapies "lack medical justification and represent a serious threat to the health and well-being of affected people."

(m) Minors who experience family rejection based on their sexual orientation face especially serious health risks. In one study, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. This is documented by Caitlin Ryan et al. in their article entitled Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults (2009) 123 Pediatrics 346.

(n) California has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender youth, and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts.

(o) Nothing in this act is intended to prevent a minor who is 12 years of age or older from consenting to any mental health treatment or counseling services, consistent with Section 124260 of the Health and Safety Code, other than sexual orientation change efforts as defined in this act.

SEC. 2. Article 15 (commencing with Section 865) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 15. Sexual Orientation Change Efforts

865. For the purposes of this article, the following terms shall have the following meanings:

(a) "Mental health provider" means a physician and surgeon specializing in the practice of psychiatry, a psychologist, a psychological assistant, intern, or trainee, a licensed marriage and family therapist, a registered marriage and family therapist, intern, or trainee, a licensed educational psychologist, a credentialed school psychologist, a licensed clinical social worker, an associate clinical social worker, a licensed professional clinical counselor, a registered clinical counselor, intern, or trainee, or any other person designated as a mental health professional under California law or regulation.

(b) (1) "Sexual orientation change efforts" means any practices by mental health providers that seek to change an individual's sexual orientation. This

includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

(2) "Sexual orientation change efforts" does not include psychotherapies that: (A) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and (B) do not seek to change sexual orientation.

865.1. Under no circumstances shall a mental health provider engage in sexual orientation change efforts with a patient under 18 years of age.

865.2. Any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider shall be considered unprofessional conduct and shall subject a mental health provider to discipline by the licensing entity for that mental health provider.

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Press Release

California Psychological Association Voices Support for SB 1172 (Lieu) Banning the Use of Sexual Orientation Change Efforts (SOCE) with Minors

Sacramento, CA, August 17, 2012: The California Psychological Association (CPA) has voiced its support today for proposed state legislation that would prohibit the use of Sexual Orientation Change Efforts (SOCE) with minors. The bill, SB 1172, is authored by Sen. Ted Lieu (D-Torrance) and sponsored by Equality California.

CPA originally held an Oppose Unless Amended position on the bill, based on concerns both about the intrusion of the legislature into clinical practice as well as a concern that an overly broad definition of Sexual Orientation Change Efforts may discourage legitimate therapeutic interventions with minors seeking to explore their sexual orientation and identity. CPA, along with other CA mental health organizations, worked with Sen. Lieu's office over a period of many weeks to arrive at revised bill language, and earlier this summer removed its Oppose Unless Amended position and moved to a Neutral position on the bill.

Today, after significant reflection and discussion, CPA has agreed to support the proposed legislation. Jo Linder-Crow, PhD, Executive Director states that "CPA has a strong track record of supporting measures that protect vulnerable groups, and has long been an ally of the LGBT community. Of course we want to ensure that legitimate therapy regarding normal developmental issues of sexual orientation and identity is readily available to minors, and it is also our job to protect our members from undue risk. However, consistent with the overwhelming weight of research available, we believe that Sexual Orientation Change Efforts, where the therapist's intent is to direct, redirect, or influence an individual's sexual orientation, are potentially harmful and have no place as a part of legitimate psychological practice. We are continuing to work with the bill's Author to put measures in place that will clarify this important distinction, as a protection to licensed mental health professionals."

The California Psychological Association, an affiliate of the American Psychological Association, represents more than 4000 member psychologists in California and is the nation's largest state psychological association.

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August 24, 2012

The Honorable Ted Lieu
California State Senate
State Capitol, Room 4090
Sacramento, California 95814

Senate Bill 1172 – SUPPORT
To Prohibit Sexual Orientation Change Efforts with Minors

Dear Senator Lieu:

The Rockway Institute—a center for LGBT psychology and public policy at the California School of Professional Psychology, Alliant International University--is proud to support Senate Bill 1172. This legislation would prohibit mental health providers from engaging in sexual orientation change efforts (SOCE) with respect to minors.

Alliant is a private, not-for-profit university offering graduate study in psychology, marriage and family therapy, education, management, law and forensic studies, and bachelor's degree programs in several fields. Alliant is accredited by the Western Association of Schools and Colleges (WASC) and encompasses a family of five schools with seven California campuses, three international locations and a student body of over 4,000. The university's California School of Professional Psychology is widely recognized as educating a plurality of doctoral-level clinical psychologists in the State of California.

SOCE poses critical health risks to lesbian, gay, and bisexual people, including depression, shame, decreased self-esteem, social withdrawal, substance abuse, risky behavior, and suicidality. There is virtually no credible evidence that any type of psychotherapy can change a person's sexual orientation, and, in fact, SOCE may cause serious and lasting harms. Nearly all the nation's leading mental health associations, including the American Psychiatric Association, the American Psychological Association, the American Counseling Association, the National Association of Social Workers, and the American Academy of Pediatrics, and the American Association for Marriage and Family Therapy have studied SOCE and issued position statements about the dangers of its utilization.

California law also places restrictions on other types of controversial treatments, such as electroconvulsive therapy and psychosurgery. These may only be administered with informed consent, and in the case of psychosurgery, may not be performed on minors. Moreover, it is a fundamental role of government to protect consumers from fraudulent claims and dangerous products such as SOCE. SB 1172 would prohibit the use of SOCE on minors, regardless of the willingness of a minor, minor's parent or guardian to authorize such efforts. SB 1172 will curb questionable practices known to produce lifelong damage to those who are subjected to them and ensure the overall health and safety of LGBT Californians. For these reasons, the Rockway Institute and its parent organization Alliant International University are proud to support SB 1172. We encourage all members of the Legislature to vote AYE.

Sincerely,

Robert-Jay Green, PhD
Executive Director, ROCKWAY INSTITUTE for LGBT Psychology & Public Policy
Distinguished Professor, Clinical Psychology PhD Program, California School of Professional Psychology
Alliant International University, San Francisco Campus

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WHEN THERAPISTS DO NOT WANT THEIR CLIENTS TO BE HOMOSEXUAL: A RESPONSE TO ROSIK'S ARTICLE

Robert-Jay Green
California School of Professional Psychology at Alliant International University

This commentary is a response to Rosik's " Motivational, Ethical, and Epistemological Foundations in the Treatment of Unwanted Homoerotic Attraction" (this issue). Such treatment raises complex questions that cannot be resolved by focusing on the therapist's conservative versus liberal values. Most such clients are deeply ambivalent about their homosexual attractions. The degree to which their homosexuality is "unwanted" is highly variable among them and sometimes within them over time. Clients who are exclusively homosexual are very unlikely to be able to change their sexual attractions, whereas some clients who are bisexual may be more able to "manage" their homoerotic attractions (acting only on their heterosexual feelings). Marriage and family therapists should be able to support a client along whatever sexual orientation path the client ultimately takes, and the client's sense of integrity and interpersonal relatedness are the most important goals of all.

Although the value of therapeutic "neutrality" has been challenged in the field of family therapy, it is preferable to strive toward neutrality rather than take a partisan position when it comes to the treatment of unwanted homosexuality. If a therapist is not able to support a client's explorations and decisions initially or over the course of treatment to live as heterosexual, homosexual, or bisexual, then I believe that the therapist should excuse her/himself from treating such clients. In contrast to the frame Rosik (this issue) suggests, the treatment of clients' "unwanted homosexuality" should not be approached as mostly a matter of therapists' politics with equal pro and con (liberal vs. conservative) positions or reduced to a matter of religious debate.

There is a crucial difference between religious exhortation/proselytizing and psychotherapy, and that difference lies primarily in whose needs and beliefs are at the center of attention. I do not believe that clients can resolve any major internal conflict in therapy when the continuation of treatment is contingent on the client accepting the therapist's preferred resolution. For example, although he does not state so explicitly, Rosik seems to believe (based on his personal interpretation of the Bible) that homosexuality is a sin, and he seems willing to agree with clients who assert that homosexuality is a sin. Thus, it is unclear how he would treat clients who decided over the course of treatment that they wanted to embrace their homosexuality, as many clients seeking reorientation therapy later do (Shidlo & Schroeder, 2001). Would Rosik reject these clients and refer them elsewhere at such a juncture? Or do these clients leave treatment without explanation, sensing that he would be unable to support their new direction?

Although Rosik (this issue)—in one of the more inflammatory remarks in his article—accuses our profession of risking "a large scale form of client discrimination and abandonment" (p. 14) toward gay or bisexual clients who wish to become heterosexual, this claim is unjustified. Gay-affirmative couple and family therapists such as myself (Green & Mitchell, 2002; Laird & Green, 1996) believe just as strongly that clients should set the goals of their treatment. For example, in my practice, I personally have helped

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lesbian/gay clients stay in heterosexual marriages, and I am comfortable with this goal if clients approach it with integrity (i.e., honesty with their spouse, rather than deception). Also, more than half of my clients at any given time tend to be heterosexuals, and I fully support their being so. In contrast, Rosik seems not to feel that homosexuality is a legitimate moral choice and presumably would have a hard time or find it impossible to work with clients who start out and wish to remain lesbian or gay or wish to increase their self-acceptance. Ironically (borrowing his words), it seems that Rosik and other conversion therapists advocate "discrimination and abandonment" of gay/lesbian clients who wish to remain gay-identified.

Thus, although Rosik would have us believe that his approach is the moral or political equivalent of a "prochoice" position, he is actually communicating a rather confusing double message. If he views the choice of homosexuality as a sin and believes that homosexuality can only to lead to unhappiness and a morally inferior life, it becomes impossible to accept his claim of giving clients any "choice" in therapy other than to adopt his views of homosexuality if they wish to remain in therapy with him. He states, for example: "MFTs who engage in reorientation therapy must respect a client's decision to leave treatment and pursue gay-affirmative therapy" (p. 19). Clearly, the implication of the phrase "leave treatment" is that such clients would be terminated and have to seek treatment elsewhere. Presumably this is because Rosik believes there is only one mentally healthy choice that could bring happiness and ethical fulfillment: heterosexuality.

Despite his pronouncements to that effect, the research literature on lesbian/gay psychology shows clearly that acceptance of one's sexual orientation and finding social support within the lesbian/gay community are the strongest predictors of mental health (Diplacido, 1998; Herek, 1998; Meyer & Dean, 1998). The majority of lesbian/gay people are as happy and mentally healthy as heterosexuals, even if the overall group means differ slightly in large population rates of substance use, depression, and attempted suicide (Bell & Weinberg, 1978; Cochran, 2001; Gonsiorek, 1991). The researchers attribute these small (but statistically significant) differences in group averages to the greater minority stress experienced by lesbian/gay people in society, whereas Rosik implies that these differences are endemic to homosexual orientation itself. If the latter were true, however, how would he explain that the vast majority of lesbian/gay people do not differ from the majority of heterosexuals in terms of substance abuse and mental health? In light of this research, it seems highly inappropriate for a therapist to support a client's jaundiced view that homosexuality is antithetical to psychological well-being and happiness, which is exactly what Rosik appears to do in his article.

Motivations for Seeking Conversion Therapy

The notion of "unwanted homoerotic attraction" is much more complex than Rosik implies in his article, particularly in his section on "motivations for pursuing greater heterosexual potential" (p. 14). Clients with these concerns run the gamut from having no same-sex experiences at all to having exclusive same-sex experiences over many years. In addition, many such clients are bisexual in attractions and/or behavior (Fox, 1996; Klein, 1993). Some of these "bisexual" clients fantasize only homosexual activity even when they are having heterosexual sex.

Many clients who are seeking treatment for unwanted homoerotic attraction are actually rather ambivalent about it. They say they do not want to be homosexual, yet they continue homosexual behavior and do not show serious intent to change. Others seem to be saying something like "I'm okay with being homosexual, but I'm afraid my parents, employers, children, or friends will find out and reject or discriminate against me." It is essential to help clients examine what is motivating their desire to change at the time treatment is started and whether their motivation is externalized or internalized, temporary in response to some precipitating event (e.g., a breakup of a same-sex relationship, or an attempt to appease a heterosexual spouse who discovered an affair), or persistent over time. As every therapist knows, almost no presenting problem or treatment is quite as simple and straightforward as it might appear to be at the outset, and many attempts to change that are begun "under duress" (due to external pressures) meet with initial success but are not sustained over time.

There are many minority human traits that may be "unwanted" by their holders in our society (e.g., ethnic appearance, body shapes that do not match the cultural ideal, foreign accents), but these attributes are

undesired because someone (or some group) defines them as undesirable, not because they are problematic in and of themselves (Green, 1998). In addition to facing external prejudice and discrimination, members of minority groups frequently internalize society's irrational views of their group traits and suffer various levels of psychological distress as a result (DiPlacido, 1998; Meyer & Dean, 1998). However, often their internalization of society's prejudice is highly conflicted because they simultaneously understand that prejudice is arbitrary, irrational, and can be resisted. Although some of these minority group traits might be changeable (e.g., plastic surgery to reshape a nose, or surgery to remove epicanthic folds in eyelids), it is valuable to inquire what motivates such clients to seek change, whether change in that trait is possible, what obstacles exist to accepting one's "differentness," rather than trying to eliminate it, and what advantages/disadvantages might follow from embracing one's individuality and minority status versus trying to conform to the dominant social norms of the majority group.

Clearly, there are some therapeutic goals (for example, an anorectic's goal to become even thinner; an abusive husband's desire to increase his dominance over his wife) that therapists may not be able to support because the achievement of those goals would severely threaten the well being of the client or another family member. For these reasons, the first steps in the treatment of "unwanted homoerotic attraction" should include efforts to understand with the client why he/she does not want homoerotic attraction. I do not mean that one should dismiss or refute the client's stated goals. Rather, that it is important to try to understand the basis of the client's motivation to change and whether it is internalized and stable (versus externalized and ambivalent) or based on negative stereotypes about homosexuality (such as the false ideas that gay people are invariably unhappy, lonely in old age, promiscuous, unable to establish lasting relationships, afflicted with HIV, etc.), some of which Rosik actually endorses in his article.

For example, Rosik suggests in his "motivations" section that many male clients justifiably want to rid themselves of homoerotic desire because of the heightened risk of contracting HIV in sex with gay men. However, most of the people in the world with AIDS now are heterosexuals (in Africa), and lesbians have the lowest rates of HIV infection. By using Rosik's logic (that homosexual clients should seek to become heterosexual to lessen their risks of contracting HIV), one could argue just as easily that heterosexual women should be encouraged to become lesbians to reduce their chances of contracting HIV. The fact is that homosexuality does not cause AIDS. Unsafe sex with HIV-positive partners (heterosexual or homosexual) causes AIDS. Obviously, the solution in HIV prevention is safer sex, not sexual orientation conversion therapy for heterosexual women and gay men.

Likewise, the solution to the unique mental health stresses faced by lesbians and gay men is a reduction in the prejudice to which they are subjected. Research shows quite clearly that external discrimination (homophobia) and internalized homophobia (Malyon, 1982; Shidlo, 1994) are strong predictors of depression, suicidality, and HIV-risk behaviors among gay, lesbian, and bisexual persons. Lesbians and gay men who are more self accepting of their sexual orientations, who receive more acceptance of their sexual orientation from family, friends, or coworkers, and who are more involved in the gay community have lower rates of mental health problems and HIV risk behaviors than do lesbians/gay men who are less self accepting and less identified with the gay community (Green & Mitchell, 2002; Herek, 1998; Meyer & Dean, 1998). Rosik seems to have gotten these results backwards in his "motivations" section. He seems to be arguing that gay/lesbian persons who accept and live out their sexual orientations will have greater mental health problems, but the research shows the opposite to be true.

The Possibility of Eliminating Homoerotic and Increasing Heteroerotic Potential

At the outset, we need to clarify that the terms heterosexual, bisexual, and homosexual are much more complicated than their casual usage by Rosik and most authors writing on these topics imply. As readers may know, Kinsey (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) counterpoised heterosexuality and homosexuality on a single bipolar continuum, which ranged from exclusive heterosexuality (0) to exclusive homosexuality (6):

0 = Exclusively heterosexual
1 = Predominantly heterosexual, only incidentally homosexual
2 = Predominantly heterosexual, but more than incidentally homosexual
3 = Equally heterosexual and homosexual
4 = Predominantly homosexual, but more than incidentally heterosexual
5 = Predominantly homosexual, only incidentally heterosexual
6 = Exclusively homosexual

However, in this rating system, Kinsey did not distinguish the person's overt sexual behavior from underlying feelings, attractions, or fantasies, nor did he distinguish either of these dimensions from the person's self-labeling or presentation to others (as heterosexual, bisexual, or gay/lesbian). By putting heterosexuality and homosexuality on a single bipolar continuum, Kinsey created a kind of "zero sum game," in which it was assumed that the more one was heterosexual, the less one was homosexual, and vice versa.

More recently, theorists such as Klein (1993) have suggested that several other theoretical continua are needed to understand a person's sexual orientation. Revising Klein's framework, I would suggest that it is most important to take into account the person's attractions, behavior, self-identification, and self-presentation, as follows:

1. Degree of *heterosexual attractions* (from high to low)
2. Degree of *heterosexual behavior* (from high to low)
3. Degree of *homosexual attractions* (from high to low)
4. Degree of *homosexual behavior* (from high to low)
5. *Self-identity* (self-labeling) as heterosexual, bisexual, or gay/lesbian
6. *Self-presentation* to others as heterosexual, bisexual, or gay/lesbian

In contrast to Kinsey, there is no reason to believe that the strength of one's heterosexual attractions diminishes one's homosexual attractions or vice-versa. That is, one may have a high degree of attraction to persons of both sexes; or a low degree of attraction to persons of both sexes; or be highly attracted to one sex and not to the other at all; or have all other possible combinations of levels of attractions to males and females. Likewise, for behavior, some people are high in heterosexual activity and simultaneously high in homosexual activity and others are low in both, with most people higher in heterosexual attractions and behavior.

In this framework, sexual orientation can best be conceptualized as encompassing several dimensions, and the person's functioning across those dimensions may or may not be consistent. For example, Ms. Smith may be strongly attracted to women but only have sex with men (while fantasizing only about women); and she may inwardly label herself as "bisexual" but present herself to others as exclusively heterosexual. In general, greater levels of incongruity among the dimensions are associated with greater levels of internal conflict, relationship dissatisfaction, and potential dissolution of relationships over time.

It is not clear whether Rosik believes that all clients seeking treatment for unwanted homoerotic attraction stand an equal chance of success at conversion. For example, in his review of the developmental research, Rosik erroneously stated that the link between gender nonconformity in childhood and homosexual orientation in adulthood "indirectly supports the potential for increasing heterosexual potential" (p. 16). However, this whole line of scientific evidence actually does the opposite. It shows that sexual orientation in these cases is part of a continuous developmental process that begins quite early in life, manifesting as cross-gender behavior during childhood and manifesting as homosexual orientation later, in adulthood (Bailey & Zucker, 1995; Bell, Weinberg, & Hammersmith, 1981; D'Augelli & Patterson, 1995; Green, Bettinger, & Zacks, 1996). Most researchers interpret this finding as evidence for the immutability of sexual orientation, concluding that it must be highly resistant to change, given the enormous social sanctions that gender nonconforming children and lesbian/gay adults encounter throughout life.

Thus, most sexologists tend to believe that sexual attractions are relatively fixed early in life, whereas sexual behavior, self labeling, and self presentation can vary dramatically according to situational and personality factors. Some of the sex therapy literature indicates that clients who start out as truly bisexual in their attractions may be able to suppress their homosexual activity and increase their heterosexual activity at least temporarily during the treatment period or beyond (Masters & Johnson, 1979). However, clients who

are exclusively homosexual (in terms of attractions) are very unlikely to succeed in developing enduring heterosexual attractions. Some proportion of the latter clients may be able to engage in temporary heterosexual behavior while utilizing homosexual fantasies. However, most of them would not find this mode of sexual expression sufficiently fulfilling emotionally over the long term. As one might imagine, the maintenance of changes after treatment in these different subgroups of clients may be quite variable depending on their degree of initial bisexual versus homosexual attractions.

Lastly, it is worth noting that women seem to be somewhat more fluid in their sexual orientation than are men, and the reasons for this difference are not entirely known (Peplau & Garnets, 2000). One may speculate, however, than women are aroused sexually more by emotional and interactional aspects of a romantic relationship, whereas men are more aroused by visual stimuli alone. Also, for obvious anatomical reasons, men require a relatively higher degree of attraction and physical arousal to participate in sexual intercourse, whereas woman can often participate at much lower levels of arousal or in its absence. This enables women to move more easily from heterosexual to lesbian relationships or vice-versa, regardless of their degree of sexual arousal in those relationships.

Research on Conversion Therapy

Rosik's entire article seems based on the premise that unwanted homoerotic attraction could be eliminated and heterosexual responsiveness developed through reorientation therapy. To support this contention, he presents a selective review of the research on this topic, emphasizing studies conducted by religiously based researchers whose findings are consistent with his point of view, while omitting the most significant research (e.g., Shidlo & Schroeder, 2001) that throws those findings into question. However, even the research he emphasizes shows that a majority of participants in conversion therapies fail to attain their goals.

For example, Rosik cites the survey by Nicolosi, Byrd, and Potts (2000) showing that 18% of participants in conversion therapy changed to becoming exclusively heterosexual and 17% almost entirely heterosexual. But this leaves two-thirds of clients who failed to attain or nearly attain the sought-after changes. Rosik also touts research by Shaeffer, Hyde, Kroencke, McCormick, and Nottebaum (2000) but then advises that: "These results did not support the short-term benefit of change-oriented therapy and speak more to modification of homosexual behavior rather than feelings" (p. 17).

With more fanfare, Rosik then presents the results of a recent study by Spitzer (2001*a*), who specifically sought research subjects who claimed to have changed their sexual orientations as a result of conversion therapy. This research design cannot yield information on what percentage of attempters succeed or fail to convert. Rather, it reveals only what self-described converters have to say about their experiences. Many, if not most, of Spitzer's research participants were religious conservatives and were referred by religious ex-gay groups. Although Rosik selectively reports some of Spitzer's data to buttress his contention that lesbian/gays can change their sexual orientations, it is interesting that Spitzer (2001*b*) himself draws a much more cautious conclusion from the study:

> Complete change was uncommon. . . . In reality, change should be seen as complex and on a continuum. Some homosexuals appear able to change self-identity and behavior, but not arousal and fantasies; others can change only self-identity; and only a very few, I suspect, can substantially change all four. Change in all four is probably less frequent than claimed by therapists who do this kind of work; in fact, I suspect the vast majority of gay people would be unable to alter by much a firmly established homosexual orientation (Spitzer, 2001*b*).

Furthermore, there is reason to doubt the veracity of research participants who were referred by religion-oriented conversion treatment programs (as was the case in the studies by Shaeffer et al., 2000; Nicolosi et al., 2001; and Spitzer, 2001*a*). For example, Exodus (which is listed in the appendix to Rosik's article and is the largest of the ex-gay religious groups) was founded in 1976 by Michael Bussee, Gary Cooper, and others. Bussee became one of Exodus's main leaders and spokespersons. However, even as they claimed to be ex-gays and worked to convert others to heterosexuality, Bussee and Cooper secretly were involved with each other romantically and sexually, and they subsequently left Exodus together in 1979. In interviews

later, Bussee stated:

> "The desires never go away. . . . The confrontations begin and the guilt gets worse and worse." Bussee recalled that some people who went through the Exodus program had breakdowns or committed suicide. "One man slashed his genitals with a razor and poured Drano on his wounds. Another man impulsively underwent an incomplete sex-change operation because he believed his sexual desires might receive divine approval were he biologically a woman." After dealing with hundreds of people, Bussee concluded that he and his partner had not "met one who went from gay to straight. Even if you manage to alter someone's sexual behavior, you cannot change their true sexual orientation. . . . If you got them away from the Christian limelight . . . and asked them, 'Honestly now, are you saying that you are no longer homosexual and you are now heterosexually oriented?'...not one person said, 'Yes, I am actually now heterosexual.'" (Mills, 1999).

More recently, John Paulk, a gay man who undertook conversion therapy with Exodus and claimed to have converted to heterosexuality, was appointed Chairman of the Board of Exodus North America. He married an "ex-lesbian" and frequently was described at the time as the "poster child" of the ex-gay movement, becoming its main public spokesman and appearing very frequently on television and other news media. However, in September 2000, Paulk was spotted in a gay bar in Washington, DC. He claimed initially that he did not realize that he had walked into and was sitting in a gay bar. However, he later recanted this story and was put on probation by the Exodus North America board of directors for what the board described as Paulk's "lapse" in judgment (Exodus North America, 2000).

These episodes among the leaders of Exodus throw into serious doubt the statements religious "ex-gays" make about their sexual orientations to the media and to researchers. For obvious reasons, members of fundamentalist religious groups have very strong incentives to be in denial or to hide their sexual orientations from researchers who are studying their group's treatment outcomes. Spitzer's follow-back sample of ex-gays was made up mainly of such persons. Given the history of duplicity among the leadership of Exodus as described above, it is difficult to determine whether self-reports given over the telephone by religious "ex-gay" research participants in the studies cited by Rosik were valid.

In contrast to Spitzer's (2001*a*) study of self-described "ex-gays," Shidlo and Schroeder (2001) undertook a survey of all clients who had attempted sexual orientation conversion treatment, regardless of whether or not they had succeeded in changing their sexual orientation. These authors found that the attempt to convert was itself severely damaging psychologically to many clients; that it reflected and contributed to their self-hatred; and that it delayed the ultimate acceptance of their sexual orientation later in life. Furthermore, Shidlo and Schroeder found that many clients involved in such treatments had lied to their therapists about continuing homosexual activity. Their conversion therapists never learned of the longer-term outcomes, which usually involved more therapy later on and ultimate acceptance of homosexuality.

Of the 202 participants in Shidlo and Schroeder's (2001) study who had participated in some form of conversion therapy, only eight participants (about 4%) reported having achieved the goal of being in a heterosexual relationship and not struggling with homoerotic desires/behavior. Of these eight participants, seven provided ex-gay counseling, and four of the seven had paid positions as ex-gay or conversion counselors. In other words, this shift in sexual orientation may have been sustained partially by work involvements as well as by participation in treatment. But even if these eight successful cases (out of 202 attempts) are genuine and permanent conversions, the generally high failure rate of conversion therapy (96%) found by Shidlo and Schroeder has to be addressed in terms of the ethical implications for clients who are seeking to eliminate homoerotic attractions.

Given the above studies, it is probably fair to conclude from the existing research that only a very small percentage of exclusively gay/lesbian people could undertake a significant degree of heterosexual involvement and feel reasonably content in doing so. Mostly, the changes that could be achieved would be behavioral and in terms of identity, rather than in terms of underlying attractions. These "ex-gays" could engage in heterosexual relationships and present themselves as heterosexual despite predominant

homosexual attractions and despite using homosexual fantasies during heterosexual encounters. For some strongly religious clients or clients with few relationship alternatives, this adaptation may be adequately satisfying and workable, especially if their partner/spouse were aware and willing to accommodate the situation, as is sometimes the case.

However, for most other predominantly homosexual clients, the large discrepancy between their attractions and their behavior would become intolerable over time, and they would feel that a deeper love and emotional fulfillment was missing in their lives. The fact remains that most homosexual (as opposed to bisexual) clients seeking conversion therapy are simply unable to make a sustained shift to heterosexuality, especially in underlying attractions, rather than in overt behavior or self-presentation. Many of these clients continue to engage in homosexual activity during and/or after treatment, and the vast majority of them are likely to accept a lesbian/gay identity later in their lives, after conversion therapy ends (see Duberman, 2002, and Moor, 2001, for very poignant case examples).

Ethical Issues

Given the high likelihood of failure in the treatment of unwanted homoerotic attraction, serious ethical issues arise regarding informed consent and the possibility that such failed therapy will be harmful to clients. If, as even the religion-motivated research cited by Rosik shows, the vast majority of clients who undertake conversion therapy do not succeed at suppressing their homosexuality and converting to heterosexuality, then therapists have an ethical obligation to so inform clients at the outset of treatment.

In addition, there is much documentation of the destructive effects that certain sexual orientation conversion treatments have had on lesbian/gay/bisexual people. These treatments often exacerbate internalized homophobia and all of its correlates, such as self-hatred, depression, suicidality, drug abuse, and HIV-risk behaviors (Garnets, Hancock, Cochran, Godchilds, & Peplau, 1991; Schroeder & Shidlo, 2001; Shidlo, Schroeder, & Drescher, 2001). Clients need to be informed of these risks at the start of therapy and advised to discuss with their therapists any signs that the therapy is making things worse, rather than better.

Obviously, no psychotherapeutic treatments are 100% successful. However, conversion therapy appears to fail such a significant amount of the time and to be harmful such a large proportion of the time that this issue of informed consent seems essential to raise with a client. The most ethical stance is to: (a) present the information on conversion therapy outcomes as it currently exists in the scientific literature as summarized above; (b) inform the client that this literature is still not definitive; (c) indicate one's willingness to continually review the client's progress toward goals as therapy progresses and to stop therapy if it is unhelpful or harmful; (d) indicate that the continuation of therapy is not contingent on the client selecting any particular sexual orientation; and (e) emphasize that the main concern of therapy will be the client living his or her life with the greatest degree of interpersonal relatedness (connection and compassion) and with integrity (differentiation of a "whole self" based on lived experience, rather than a "pseudo-self"). This stance allows the client to fully utilize his/her religious values in deciding whether and how to express sexuality with integrity. It also leaves the client free to attempt heterosexuality and still provides a safety net and psychological help if the client does not achieve that goal or changes goals along the way.

What is Rosik's "Treatment of Unwanted Homoerotic Attraction?"

Although the title of Rosik's article refers to a "treatment," it is noteworthy that there is almost no description of that treatment. Instead, the author focuses almost exclusively on the polemics of liberal versus conservative therapists' acceptance of the client's initial goal to become heterosexual. In addition, while claiming that his approach is grounded in religion, Rosik overlooks other religious perspectives and interpretations of the Bible that help clients incorporate their religious beliefs into a positive gay identity (see the website of PFLAG—Parents, Families, & Friends of Lesbians and Gays—for a continually updated reading list on "Homosexuality and Religion," www.pflag.org). Thus, Rosik's article remains rather abstract throughout, tending toward caricatures of liberal and conservative therapists, but avoiding the nitty-gritty information about how to conduct this treatment with real people.

For example, Rosik states: "Conservatives, in contrast, tend to grapple with a broader and more multifaceted moral domain that extends beyond the EOA to include two other influential dimensions in their

evaluative framework: the ethics of community (EOC), and the ethics of divinity (EOD)" (p. 20). He then explains that this larger domain goes beyond the "ethics of autonomy (EOA)" (which are supposedly the only ethics embraced by liberal therapists) to include the "ethics of community (EOC)" and the "ethics of divinity (EOD)," the latter referring to Biblical and other religious precepts. However, it is completely arbitrary to state that liberal therapists are concerned only with the ethics of autonomy and not with the ethics of community or divinity, and to anoint conservative therapists the keepers of a "larger" (presumably superior) morality compared to the rest of the professional and academic community. There simply is no basis for claiming that the bulk of therapists are dealing with a smaller moral domain than conservative therapists or for assuming that conservative religious therapists' applications of the Bible are superior to those of other, less conservative therapists with religious affiliations. Yet this is the kind of ad hoc reasoning that makes much of Rosik's writing about moral epistemology so polemical at the core.

The omission of a treatment method description is quite worrisome, because many religious conversion programs seem to use techniques that are ethically questionable from the standpoint of mainstream psychological treatments. In addition, readers are unable to evaluate the merits of Rosik's treatment techniques even on theoretical or logical grounds, because these techniques were never described. For example, does Rosik engage in various combinations of Biblical study, prayer groups, and pastoral counseling? Exorcisms or other rituals based on a sin-based conception of homosexuality? Aversion therapy to decrease homosexual attractions, or classical conditioning techniques to increase heterosexual attractions? Does the treatment use fear-based tactics with references to Satan and punishment in the afterlife?

Frequently, conversion therapists authoritatively attribute the cause of homosexuality to factors that research has shown are completely unrelated to the development of sexual orientation. Such attributions seem unethical in light of the existing research. For example, that old psychodynamic saw of blaming "overinvolved mothers and/or distant fathers" for a child's homosexual orientation (and for almost every other psychological problem) is still frequently used by conversion therapists, even though research findings have long since put that notion to rest (Bell et al., 1981). In fact, no family patterns have been found to bear a causal relationship to the development of homosexuality. Nor has child physical or sexual abuse been found to bear a relationship with homosexuality. No longitudinal studies on this question have been conducted, and some studies show that the rates of such prior abuse are identical for heterosexual and lesbian women (Herman, 1992), yet this is another frequent interpretation offered to clients by conversion therapists.

Because he does not give us specifics, we are left with many more questions than answers when it comes to understanding Rosik's clinical treatment for unwanted homoerotic attraction. I invite Dr. Rosik to provide in his rejoinder a more tangible description of the treatment, however briefly. We need to know what sorts of interpretations, homework assignments, suggestions, adjunctive treatments, referrals, religious activities, and sequences of interventions are typically used in his method of therapy. We need to know what information about sexual orientation the clients are advised to disclose to their spouses or dating partners, and whether and how spouses or partners are involved in the treatment. We also need to know how therapists working in Rosik's framework would respond if a client changed goals and decided to try to accept his/her homosexuality during the course of treatment. Lacking such basic information, it is impossible for readers to adequately evaluate Rosik's treatment methods or his ethics.

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