



The Hidden Truth About Changing Sexual Orientation: Ten Ways Pro-LGBT Sources Undermine the Case for Therapy Bans

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SUMMARY:

Eleven states have enacted legislation to prohibit licensed mental health providers from engaging in sexual orientation change efforts (SOCE), sometimes referred to by critics as “conversion therapy.” Most of this “therapy ban” legislation has cited a 2009 *Task Force Report* by the American Psychological Association (APA) to discredit SOCE. This report downplays the evidence that SOCE are effective and beneficial, and exaggerates the evidence that they are harmful. However, because of its effort to be (or to appear) comprehensive, the task force report actually makes a number of concessions which *undermine the argument for legally restricting SOCE*. This paper consists of ten key points which weaken the case for therapy bans. Each of these ten points is backed up by evidence cited from *sources which support the acceptance of homosexual relationships and identities* (and most of them from the APA’s *Task Force Report* itself). Rejection of therapy bans would allow the public and social debate about the merits and limitations of SOCE to continue, while at the same time winning a victory for personal freedom for *all*—including that small population of people who experience same-sex attractions as unwanted, and the therapists willing to help them achieve their own goals.

Introduction

Maryland recently became the eleventh state¹ to enact legislation to prohibit licensed mental health providers from engaging in sexual orientation change efforts (“SOCE;” sometimes referred to by critics as “conversion therapy”) with minors. This paper will refer to such restrictions as “therapy bans.”

The first source cited in the Maryland bill (and most similar laws or bills) is a 2009 *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, published by the American Psychological Association (APA). This report is critical of SOCE and seeks to discourage clients and therapists from undertaking such therapy.

While numerous other professional organizations have subsequently come out with statements criticizing SOCE, those are virtually all *policy* statements only (adopted by small committees, not the full membership of those organizations). Any claims about the research on SOCE are generally derived from the 2009 APA *Task Force Report*.

Much of what is found in the APA’s *Task Force Report* is highly problematic. The authors display a strong bias in favor of homosexual behaviors and identities, and are clearly biased against those who may consider such behaviors or identities in any way undesirable (for any reason, including health concerns

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and religious convictions). The report downplays the evidence that SOCE are effective and beneficial, and exaggerates the evidence that they are harmful. However, *at no point in this Report does the APA call for legal restrictions to be placed upon SOCE.*

In fact, because of its effort to be (or to appear) comprehensive, the task force actually makes a number of concessions which *undermine the argument for legally restricting SOCE.* Too many people have relied only upon the negative summary statements about SOCE issued by the APA (and bodies purporting to represent other, similar professional organizations), without looking at what the *actual* research shows (or fails to show).

This paper consists of ten key points (summarized on the next two pages, but then listed individually) which undermine the argument for legal restrictions such as those found in Maryland's SB 1028, or the even more draconian rules now under consideration in California (AB 2943). Each of these ten points is backed up by evidence cited from *sources which support the acceptance of homosexual relationships and identities* (and most of them from the APA's Task Force Report itself).

None of the sources cited here are social conservatives, ex-gays, or therapists who currently engage in SOCE. (All those groups have a valuable contribution to make to this debate and deserve a respectful hearing, but for purposes of this publication I am focusing only on *LGBT-affirming* sources.) I am including after each point the full quotation from the source with key portions highlighted in italics.

This legislation, on its face, interferes with the freedom of both clients and therapists. Therefore, the burden of proof must rest on those who would engage in such an unprecedented infringement on personal freedom. The evidence required to justify such an invasion of freedom and privacy is simply absent. *Opposing legislation that would ban sexual orientation change efforts does not require endorsing their use.* In a free society, people are *allowed* to do many things that others consider unwise, without legal interference by the state.

Rejection of therapy bans would allow the public and social debate about the merits and limitations of SOCE to continue, while at the same time winning a victory for personal freedom for *all* – including that small population of people who experience same-sex attractions as unwanted, and the therapists willing to help them achieve their own goals.

Summary of the Ten Points

1) Opposition to SOCE is based in part on the belief that people are born gay, probably as a result of a "gay gene" or some other biological factor present at birth.

However, the APA admits that "there is no consensus among scientists" about what causes homosexuality, and that "nurture" may play a role.

2) Opposition to SOCE is based on the belief that sexual orientation is fixed and unchangeable.

However, the APA has acknowledged that "for some, sexual orientation identity . . . is fluid or has an indefinite outcome."

3) Scientific research has clearly shown that the sexual identities of adolescents in particular (the population targeted by most of the proposed therapy bans) are fluid, not fixed.

Two papers by Ritch Savin-Williams of Cornell University, probably the country's leading expert on sexual minority youth, document that such fluidity is most common among those who at some point have expressed "non-heterosexual" attractions, behaviors, and identities.

4) Opposition to SOCE, especially for children and adolescents, is based on the belief that individuals are generally coerced into undergoing therapy (e.g., by parents).

However, the APA acknowledges that some people, including children and adolescents, may experience "distress" about having same-sex attractions and consider such feelings to be unwanted, without mention of any outside coercion.

5) Most of the therapy bans that have been enacted or proposed are targeted specifically at minor clients.

However, the APA acknowledges that there has been virtually *no* actual research done on sexual orientation change efforts with children or adolescents.

6) Opposition to SOCE is premised on the belief that it has no benefits for the clients who undertake it.

However, the APA acknowledged, "Some individuals perceived that they had benefited from SOCE . . ."

7) Opposition to SOCE is based on the claim that such efforts are never effective in changing an individual's sexual orientation.

However, Nicholas A. Cummings, a former president of the American Psychological Association and former chief psychologist for Kaiser Permanente, wrote in *USA Today* that "of the patients I oversaw who sought to change their orientation, hundreds were successful."

8) Opposition to SOCE is based on the claim that it is always (or at least usually) harmful to clients.

However, the APA admits that there is *no* "valid causal evidence" that SOCE is harmful.

9) The APA acknowledges that licensed mental health providers (LMHP) should "respect a person's (client's) right to self-determination," allow the client to choose her or his own goals, and "be sensitive to the client's . . . religion."

However, therapy bans *directly violate* this core ethical principle of client self-determination.

10) As noted earlier, legislative restrictions on sexual orientation change efforts with minors are based on the belief that such therapy always (or usually) occurs as a result of coercion by parents or other adults.

However, the APA has acknowledged that concerns about potential coercion could be mitigated by implementing a system of "developmentally appropriate informed consent to treatment."

1) No one is “born gay.”

Opposition to SOCE is based in part on the belief that people are born gay, probably as a result of a “gay gene” or some other biological factor present at birth.

However, the APA admits that “there is no consensus among scientists” about what causes homosexuality, and that “nurture” may play a role (emphasis mine):

What causes a person to have a particular sexual orientation?

There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation.

“Sexual Orientation & Homosexuality,” American Psychological Association, accessed May 18, 2018, <http://www.apa.org/topics/lgbt/orientation.aspx>.

2) Sexual orientation can be fluid.

Opposition to SOCE is based on the belief that sexual orientation is fixed and unchangeable.

However, the APA has acknowledged that “for some, sexual orientation identity . . . is fluid or has an indefinite outcome” (emphasis mine):

- Same-sex sexual attractions and behavior occur in the context of a variety of sexual orientations and sexual orientation identities, and *for some, sexual orientation identity* (i.e., individual or group membership and affiliation, self-labeling) *is fluid or has an indefinite outcome.*

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 2, <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

3) Sexual identities of adolescents are even more fluid than those of adults.

Scientific research has clearly shown that the sexual identities of adolescents in particular (the population targeted by most proposed therapy bans) are fluid, not fixed.

Two papers by Ritch Savin-Williams of Cornell University, probably the country’s leading expert on sexual minority youth, document that such fluidity is most common among those who at some point have expressed “non-heterosexual” attractions, behaviors, and identities (emphasis mine):

In the data set of the longitudinal Add Health study, of the Wave I boys who indicated that they had exclusive same-sex romantic attraction, only 11% reported exclusive same-sex attraction 1 year later; 48% reported only opposite-sex attraction, 35% reported no attraction to either sex, and 6% reported attraction to both sexes (Udry & Chantala, 2005).

Ritch C. Savin-Williams, "Who's Gay? Does It Matter?" *Current Directions in Psychological Science* 15:1 (2006): 42, accessed May 18, 2018,

<https://www.human.cornell.edu/sites/default/files/HD/sexgender/CurrentDirections.pdf>.

Migration over time among sexual orientation components was in both directions, from opposite-sex attraction and behavior to same-sex attraction and behavior and vice versa.

...

Stability of nonheterosexuality

Although Laumann et al. (1994) expressed doubt about the extent to which nonheterosexual sexual categories, behaviors, and attractions remained stable over time, most investigators presume the stability of sexual orientation and thus assess it at one point in time. This might be a particularly problematic tactic with adolescent and young adult populations, a time in which individuals experiment with their sexuality Yet, researchers readily acknowledge the existence of such sexual groups ("gay youth") with little evidence that these individuals will be in the same group a month, a year, or a decade henceforth.

Evidence to support sexual orientation stability among nonheterosexuals is surprisingly meager. . . .

Support for the instability of sexual orientation is far more prevalent—in both adult and adolescent populations. Among the 14% of Dutch adult males who reported ever having physical attraction to other males, about half noted that these feelings disappeared later in life (Sandfort, 1997).

...

Over time, lesbian and bisexual identities lost the most adherents and heterosexual and unlabeled identities gained the most.

...

Although most (97%) heterosexuals maintained their heterosexual identity, nonheterosexuals frequently changed their identity label over the life course: 39% of gay males, 65% of lesbians, 66% of male bisexuals, and 77% of female bisexuals. The dimensional assessments of fantasy, attraction, and behavior reflected similar trends. Although roughly 90% of heterosexually identified individuals had none or one point changes during their lifetime, the majority of gay (52%), lesbian (80%), and bisexual (90%) identified individuals had multiple changes on the dimensional variables.

Ritch C. Savin-Williams and Geoffrey L. Ream, "Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood," *Archives of Sexual Behavior* 36 (2007): 385-87, accessed May 18, 2018,

https://www.researchgate.net/profile/Geoffrey_Ream/publication/6605886_Prevalence_and_Stability_of_Sexual_Orientation_Components_During_Adolescence_and_Young_Adulthood/links/55253207cf22e181e73eee1.pdf.

4) Same-sex attractions can be unwanted and cause distress.

Opposition to SOCE, especially for children and adolescents, is based on the belief that individuals are generally coerced into undergoing therapy (e.g., by parents).

However, the APA acknowledges that some people, including children and adolescents, may experience “distress” about having same-sex attractions and consider such feelings to be unwanted, without mention of any outside coercion. It cited (emphasis mine):

the following populations: children and adolescents who present with *distress regarding their sexual orientation*, religious individuals in distress regarding their sexual orientation, and adults who present with *desires to their change sexual orientation* or have undergone therapy to do so.

On the other hand, APA found no data on parents who seek SOCE for their children:

Research on Parents' Concerns About Their Children's Sexual Orientation
We did not find specific research on the characteristics of parents who bring their children to SOCE.

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 8, 73,
<https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

5) There has been virtually no research on SOCE among children or adolescents.

Although most of the proposed therapy bans have been targeted specifically at minor clients, the APA acknowledges that there has been virtually *no* actual research done on sexual orientation change efforts with children or adolescents (emphasis mine):

No investigations are of children and adolescents exclusively, although adolescents are included in a very few study samples.

...

Literature Review

Literature on Children

There is a lack of published research on SOCE among children. Research on sexuality in childhood is limited and seldom includes sexual orientation or sexual orientation identity (Perrin, 2002).

...

Literature on Adolescents

We found no empirical research on adolescents who request SOCE . . .

...

Due to the limited research on children, adolescents, and families who seek SOCE, our recommendations for affirmative therapy for children, youth, and their families distressed about sexual orientation are based on general research and clinical articles addressing these and other issues, not on research specific to those who specifically request SOCE. We acknowledge that limitation in our recommendations.

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 33, 72-73, 76,
<https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

6) Some clients benefit from SOCE.

Opposition to SOCE is premised on the belief that it has no benefits for the clients who undertake it.

However, the APA acknowledged, “Some individuals perceived that they had benefited from SOCE . . .” (emphasis mine):

Former participants in SOCE reported diverse evaluations of their experiences: *Some individuals perceived that they had benefited from SOCE, . . .* [These] individuals reported that SOCE was helpful—for example, *it helped them live in a manner consistent with their faith*. Some individuals described finding a *sense of community* through religious SOCE and valued having *others with whom they could identify*. These effects are similar to those provided by mutual support groups for a range of problems, and the positive benefits reported by participants in SOCE, such as *reduction of isolation*, alterations in how problems are viewed, and *stress reduction*, are consistent with the findings of the general mutual support group literature.

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 3, <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

7) SOCE can be effective.

Opposition to SOCE is based on the claim that such efforts are never effective in changing an individual’s sexual orientation.

Nicholas A. Cummings a former president of the American Psychological Association and former chief psychologist for Kaiser Permanente, declares, “Gays and lesbians have the right to be affirmed in their homosexuality.” However, he also wrote in *USA Today* that “of the patients I oversaw who sought to change their orientation, hundreds were successful” (emphasis mine):

Individual’s goals

They generally sought therapy for one of three reasons: to come to grips with their gay identity, to resolve relationship issues or *to change their sexual orientation*. We would always inform patients in the third group that change was not easily accomplished. With clinical experience, my staff and I learned to assess the probability of change in those who wished to become heterosexual. Of the roughly 18,000 gay and lesbian patients whom we treated over 25 years through Kaiser, I believe that most had satisfactory outcomes. The majority were able to attain a happier and more stable homosexual lifestyle. *Of the patients I oversaw who sought to change their orientation, hundreds were successful.*

I believe that *our rate of success with reorientation was relatively high* because we were selective in recommending therapeutic change efforts only to those who identified themselves as highly motivated and were clinically assessed as having a high probability of success.

Nicholas A. Cummings, “Sexual reorientation therapy not unethical: Column,” *USA Today*, July 30, 2013, accessed May 18, 2018, <https://www.usatoday.com/story/opinion/2013/07/30/sexual-reorientation-therapy-not-unethical-column/2601159/>.

8) There is no proof that SOCE is harmful.

Opposition to SOCE is based on the claim that it is always (or at least usually) harmful to clients.

However, the APA admits that there is *no* “valid causal evidence” that SOCE is harmful (emphasis mine):

RECENT STUDIES

Although the *recent studies do not provide valid causal evidence* of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE . . . , just as other *recent studies document that there are people who perceive that they have benefited from it*

. . .

Summary

We conclude that there is a dearth of scientifically sound research on the safety of SOCE. *Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE.*

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 42, <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

9) A person’s right to self-determination must be respected.

The APA acknowledges that licensed mental health providers (LMHP) should “respect a person’s (client’s) right to self-determination,” allow the client to choose her or his own goals, and “be sensitive to the client’s . . . religion.”

However, therapy bans *directly violate* this core ethical principle of client self-determination, by *forbidding* the LMHP from assisting the client in achieving *the client’s own goals*, if those goals include changing *any* aspect of her or his sexual orientation (attractions, behavior, or identity) – even if the change is motivated by the client’s religious convictions (emphasis mine):

Mental health professional organizations call on their members to *respect a person’s (client’s) right to self-determination; be sensitive to the client’s race, culture, ethnicity, age, gender, gender identity, sexual orientation, religion, socioeconomic status, language, and disability status when working with that client; and eliminate biases based on these factors.*

“Answers to Your Questions: For a Better Understanding of Sexual Orientation and Homosexuality,” American Psychological Association, 2008, accessed May 18, 2018, <http://www.apa.org/topics/lgbt/orientation.pdf>, 3.

Self-determination is the process by which a person controls or determines the course of her or his own life (Oxford American Dictionary, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client’s assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) *permitting the client herself or himself to decide the ultimate goal of how to self-identify and live out her or his sexual orientation.*

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 88, <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

10) A system of informed consent should be implemented.

As noted earlier, legislative restrictions on sexual orientation change efforts with minors are based on the belief that such therapy always (or usually) occurs as a result of coercion by parents or other adults.

However, the APA has acknowledged that concerns about potential coercion could be mitigated by implementing a system of “developmentally appropriate informed consent to treatment.” (Presumably, what is referred to as “rights to consent to treatment” includes the positive right to *consent* to a treatment, and not merely the negative right to *refuse* a treatment.) Emphasis mine:

ADOLESCENTS’ RIGHTS TO CONSENT TO TREATMENT

In researching involuntary treatment, we reviewed the recent literature on the growing movement to increase adolescents’ rights to consent to outpatient and inpatient mental health treatment so as to reduce involuntary hospitalization (Mutcherson, 2006; Redding, 1993). It is now recognized that *adolescents are cognitively able to participate in some health care treatment decisions, and such participation is helpful* (Hartman, 2000, 2002; Mutcherson, 2006; Redding, 1993). The APA Guidelines for Psychotherapy for Lesbian, Gay, and Bisexual Clients (2000) and the APA Ethics Code (2002b) encourage professionals to seek the assent of minor clients for treatment. Within the field of adolescent mental health and psychiatry, there are developmental assessment models to determine an adolescent’s competence to assent or consent to and potentially refuse treatment (Forehand & Ciccone, 2004; Redding, 1993; Rosner, 2004a, 2004b). Some states now permit adolescents some rights regarding choosing or refusing inpatient treatment, participating in certain interventions, and control over disclosure of records (Koocher, 2003).

...

States have different requirements and standards for obtaining informed consent to treatment for adolescents; however, *it is recognized that adolescents are cognitively able to participate in some health care treatment decisions and that such participation is helpful*. We recommend that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent’s ability to understand treatment options, *provide developmentally appropriate informed consent to treatment*, and, at a minimum, obtain the youth’s assent to treatment.

...

Psychotherapy With Children and Adolescents

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change. Consistent with the current scientific evidence, those working with children and adolescents strive to have a developmentally appropriate perspective that includes

a client-centered multicultural perspective to reduce self-stigma and mitigate minority stress. This includes interventions that (a) reduce stigma and isolation, (b) support the exploration and development of identity, (c) facilitate achievement of developmental milestones, and (d) *respect age-appropriate issues regarding self-determination*. Such services are ideally provided in the least restrictive setting and *with, at a minimum, the assent of the youth*. However, LMHP are encouraged to *acquire developmentally appropriate informed consent to treatment*.

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, DC: American Psychological Association, August 2009), 74, 79, 87, <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.

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¹ Michael Gryboski, "Maryland Becomes the 11th State to Ban Gay Conversion Therapy for Minors," *The Christian Post*, May 15, 2018, accessed May 18, 2018, <https://www.christianpost.com/news/maryland-11th-state-ban-gay-conversion-therapy-minors-governor-larry-hogan-224030/>.