AMERICAN PSYCHOLOGICAL ASSOCIATION

APA RESOLUTION **on Sexual Orientation Change Efforts**

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Sexual orientation is a multidimensional aspect of human experience, comprised of gendered patterns in attraction and behavior, identity related to these patterns, and associated experiences, such as fantasy (Katz-Wise & Hyde, 2014; Klein, 1993; Rosario & Schrimshaw, 2014). "Attraction" is conceptualized as both romantic and sexual (e.g., Rosario & Schrimshaw, 2014) and as focusing on biological characteristics of sex as well as aspects of gender identity and expression (van Anders, 2015). Individuals with same-gender and multiple-gender attractions and behaviors have been stigmatized. Heterosexism and monosexism are social stigmas and societal inequalities that denigrate, discredit, and disadvantage those with same- and multiple-gender attractions, behaviors, and associated identities (American Psychological Association [APA], 2012; Herek, 2007; Roberts, Horne, & Hoyt, 2015). Because of the social stigma they experience, individuals with same- and multiple-gender attractions and behaviors may be referred to collectively as *sexual minorities* (Herek, 2007; Savin-Williams, 2001; van Anders, 2015).

Sexual orientation change efforts (SOCE) include a range of techniques used by a variety of mental health professionals and non-professionals with the goal of changing sexual orientation (APA, 2009) or any of its parts. SOCE was a term developed by the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) to describe these efforts that have been known by several names and may take a variety of forms. The term SOCE avoids the use of the term therapy and thus the implication that there is some disorder to be treated. Some mental health professionals who have utilized or promoted SOCE have used the term "therapy" to describe their practices and/or to support the idea that sexual minority youths and adults are mentally ill due to their sexual orientation. In fact, mainstream mental health professions have rejected this idea since the 1970s.

SOCE refer to a wide variety of efforts. SOCE have taken a variety of forms such as one-on-one meetings, drop-in groups, residential programs, conferences, and online groups. Rationales for SOCE have included assertions that same-gender attractions are caused by bad parenting, peer abuse, sexual trauma, gender "inferiority," and/or unmet emotional needs. SOCE have included interventions such as recommending dating someone of a different sex; developing nonsexual intimacy and belonging with heterosexual same-gender peers; experiencing same-gender non-erotic touch; using religious practices such as prayer, scripture study, exorcism, and confessing same-gender attractions; implementing aversive conditioning; practicing traditional gender expression and gender role behavior; and suppressing gender nonconforming behaviors (APA, 2009; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Hipp, Gore, Toumayan, Anderson, & Thurston, 2019; Flentje, Heck, & Cochran, 2013; Rix, n.d.). The wide variety of SOCE are not consistently reflected in SOCE literature and popular culture. As the latter examples of interventions indicate, SOCE have not only targeted sexual and romantic behavior but also gender expressions that do not conform to stereotypes. In this way, gender identity change efforts have also been a component of SOCE. A focus on White cisgender individuals and sexual orientation may also make less visible the impacts of SOCE on communities of color. For example, in Black Memphis communities, SOCE might not be readily identified as such but appear as violence and "church hurt" (Hipp et al., 2019). SOCE may appear differently in different social contexts.

SOCE HAVE INCLUDED ONE OR MORE OF THE FOLLOWING:

- nonscientific explanations of sexual orientation diversity that stigmatize and frame same-gender and multiple-gender orientations as unhealthy (Fjelstrom, 2013; Flentje et al., 2013; Hipp et al., 2019; Shidlo & Gonsiorek, 2017),
- claims that sexual attraction can be changed through psychotherapeutic treatment (e.g., Dehlin et al., 2015; Fjelstrom, 2013; Shidlo & Shroeder, 2002; Super & Jacobson, 2011; Weiss et al., 2010; Wood & Conley, 2014),
- pre-determined or prescribed outcomes for sexual orientation, gender-expression, or sexual identity (e.g., Bradshaw et al., 2015; Fjelstrom, 2013; Flentje et al., 2013; Ryan, Toomey, Diaz, & Russell, 2018), and
- dissemination of inaccurate information about the effects of SOCE or about sexual orientation, such as the discredited idea that same-gender orientations are caused by negative childhood events or family dysfunction (Flentje et al., 2013; Shidlo & Gonsiorek, 2017).

CONTEXTS WITH MULTIPLE STIGMAS AND VULNERABILITIES

Given the pervasive heterosexism and monosexism in society, it is no surprise that some sexual minority individuals seek to change their sexual orientation through SOCE and some parents, guardians, and custodians (e.g., foster care) seek SOCE for their sexual and/or gender minority children. Participants in studies of people who have experienced SOCE typically have less family or community support for lesbian, gay, bisexual, transgender, queer and other marginalized sexual and gender identities (LGBTQ+), more religiously orthodox backgrounds, and greater likelihood of residing in rural areas (APA, 2009; Dehlin et al., 2015). They may also experience additional inequalities such as racism and anti-immigrant stigma (Hipp et al., 2019; Ryan et al., 2018), identify as Hispanic/Latinx, identify as transgender or nonbinary, come from families with lower incomes, and have parents who use religion to say negative things about being LGBTQ+ (Green, Price-Feeney, Dorison, & Pick, 2020). Many of these associations place LGBTQ+ individuals at risk of the downstream consequences of multiple stigmas and inequalities.

Participants in studies of people who have experienced SOCE have also explained their SOCE involvement. Reasons reported for seeking SOCE have included the following: fear of rejection from family, faith community, or God/Divinity; the belief that expressions of same-gender attractions are sinful or against religious teachings; fear of an unfamiliar LGBTQ+ community; or belief in a variety of stereotypes about life as sexual minorities (e.g., beliefs that it would be impossible to have children, that sexual minorities are destined to have life-threatening illnesses, that sexual minorities can never have fulfilling relationships; APA, 2009; Haldeman, 2018). The foregoing reasons reflect the intersectional contexts of social stigma and systemic inequalities in which SOCE are embedded (APA, 2017a; Crenshaw, 1989). Some SOCE proponents reinforce these messages to their consumers (Hipp et al., 2019; Jacobsen & Wright, 2014; Schroeder & Shidlo, 2001). The connection between stigma and SOCE has long been clear. As one scholar historically stated, "The very existence of sexual orientation conversion therapy is a significant causal element in the social forces causing some people to attempt changing their sexual orientation in the first place" (Davison, 1976).

APA is particularly concerned about the significant risk of harm to minors from SOCE. LGBTQ+ individuals are exposed to individual, social, and institutional levels of stigma, which negatively affect multiple health domains (Hatzenbuehler & Pachankis, 2016; Robinson, 2017). Moreover, LGBTQ+ youth are also overrepresented in foster care, child welfare, and juvenile justice systems (Conron & Wilson, 2019; Detlaff, Washburn, Carr, & Vogel, 2018) where they face significant exposures to adverse childhood experiences. SOCE may be understood as an adverse childhood experience or trauma (Fish & Russell, 2020) that place youth at even greater risk of harm. Thus, youth and their families and custodians may be particularly vulnerable to misinformation about sexual orientation and SOCE and to the dangers of SOCE involvement.

As of December 2020, at least 20 states, D.C, and more than70 municipalities in the United States (U.S.) have adopted laws or statewide regulations prohibiting licensed mental health practitioners from using SOCE with minors (Movement Advancement Project, n.d.). However, one study estimated that in the U.S., licensed health professionals will use SOCE on 16,000 adolescents by the time those adolescents are age 18 (Mallory, Brown, & Conron, 2019). Thus, notwithstanding the change in mainstream professional opinion and the increasing prohibition of SOCE, there is significant concern that SOCE is still a problem. Based on expert consensus, the Substance Abuse and Mental Health Service Administration (SAMHSA), an agency within the US Department of Health and Human Services, concluded that "conversion therapy" should be ended with minors as they are not supported by evidence and could seriously harm youth (SAMHSA, 2015).

In recent years, U.S. SOCE proponents have attempted to further export and legitimize SOCE outside the U.S. In some cases, these efforts have resulted in dire consequences to local LGBTQ+ communities and advocates such as life imprisonment and other criminal penalties for "homosexuality" (Bailey et al., 2016; Dicklitch, Yost, & Dougan, 2012; Global Philanthropy Project, 2018; Horne & McGinley, in press). SOCE adds to harm in parts of the world where sexual and gender minorities have few legal protections, or where attitudes towards them are extremely negative even if legal protections exist (e.g., Horne & McGinley, in press ; Zahn et al., 2016). Scientifically and culturally accurate knowledge about sexual minorities is often limited or distorted in such regions and SOCE, including medical techniques such as hormone treatments (Horne & McGinley, in press) and aversive techniques such as electroshock treatment (Jahangir & Abdul-latif, 2016; Lewin & Meyer, 2002), are employed to "cure" sexual minorities. The instigation of SOCE by professionals serves to justify and reify stigma and discrimination directed against sexual minorities, making them more vulnerable to negative consequences, including human rights abuses (Horne & McGinley, in press; Lewin & Meyer, 2002; Winskell et al., 2017).

Given the transnational consequences of SOCE, SOCE are opposed by a number of health organizations, such as the British Psychological Society (Memorandum of Understanding on Conversion Therapy in the UK, 2017), and a number of national psychological associations endorsed a statement rejecting SOCE as stigmatizing and often harmful and supporting instead affirmative therapeutic interventions for sexual and gender minorities (International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues, 2018). Furthermore, countries as different as Brazil, Ecuador, Germany, Malta, and Taiwan as well as regions of Australia, Canada, and Spain have enacted laws to protect individuals from "conversion therapy"

(Chaudhry, 2018; Gstalter, 2020). In 2013, the United Nations Human Rights Council's (UNHRC) Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment stated some SOCE do rise to the level of human rights violations, labeling SOCE "abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment" (UNHRC, 2013). After a wide-ranging international exploration, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity characterized the many efforts under the term "conversion therapy" as "relying on the medically false pathologization of sexual orientation and gender identity, manifested through interventions that inflict severe pain and suffering and result in psychological and physical damage" (UNHRC, 2020, p. 5). The report denies an ethical and evidentiary basis for conversion and calls for measures to prevent conversion efforts, which it defines as "degrading, inhuman and cruel" (UNHRC, 2020, p. 21).

SCIENCE AND SOCE

SOCE lack sufficient bases in scientific principles. A variety of methodological and statistical issues have rendered many SOCE reports invalid (APA, 2009; Panozzo, 2013; Retraction notice, 2019; Spitzer, 2012). In addition to problems with their specific study designs, SOCE proponents' claims distort others' valid research. SOCE proponents' claims about the possibility of environmental influences on sexual orientation are inconsistent and lack connectivity with the ways scientific theories meaningfully integrate multiple biological and cultural factors contributing to sexual orientation (Bailey, Vasey, Diamond, Breedlove, Vilain, & Epprecht, 2016; Diamond & Rosky, 2016; Shidlo & Gonsiorek, 2017; see Tolman & Diamond, 2014, for scientific theories on sexual orientation). Failing to correct refuted claims, some SOCE proponents have referenced discredited factors in sexual orientation etiology, such as "defective" gender identity, and made inaccurate claims using psychoanalytic concepts, such as referring to sexual minorities as inherently developmentally arrested due to parent-child relationships (Isay, 1989; Shidlo & Gonsiorek, 2017). Literature on SOCE has also inaccurately applied evidence of sexual fluidity across the lifespan by distorting sexual fluidity as a justification for SOCE (Diamond & Rosky, 2016). Rather than willful shifts in sexual orientation, fluidity describes changes in awareness, attractions, behaviors, and identities that unfold over time (Diamond, 2008). However, that sexual orientation can evolve and change for some does not mean that it can be altered through intervention or that it is advisable to try.

ETHICAL CONCERNS

Application of ethical considerations about SOCE have long included concerns about their associations with stigma and their potential to be used coercively (e.g., APA, 1998). The charge to "do no harm" has historically been a foundational principle of practice for healthcare professionals. Aspirational principles such as "Respect for People's Rights and Dignity" (Principle E, APA Ethics Code), which includes respecting the rights of individuals to self-determination, are held in dynamic tension with other principles, including "Beneficence and Nonmaleficence" (Principle A, APA Ethics Code). Shidlo and Gonsiorek (2017) argued that self-determination is not intended to be used as the only or more important ethical principle in clinical decision-making. There are a number of patient-requests a psychologist would decline (e.g., a request for a behavioral weight loss program from a patient with anorexia nervosa) in the interest of the patient's health and well-being. Ethics Code Standard 2.04 also states "Psychologists' work is based upon established scientific and professional knowledge of the discipline" (APA, 2017b, p. 5). Moreover, Standard 3.04(a) of the APA Ethics Code requires that "psychologists take reasonable steps to avoid harming their clients/patients and to minimize harm where it is foreseeable and unavoidable" (APA, 2017b, p. 6). Self-determination does not necessitate or justify dispensing with other ethical obligations regarding patient care.

CURRENT CONTEXTS

Major medical and mental health care organizations in the U.S. have long raised concerns about risks of harm from SOCE. In addition to APA (1998, 2009), advisory policies against SOCE have been adopted by the American Academy of Child and Adolescent Psychiatry (2012), the American Academy of Pediatrics (1993), the American Association of Sexuality Educators, Counselors, and Therapists (2017), the American College of Physicians (2015), the American Counseling Association (2013), the American Medical Association (2019), the American Psychiatric Association (2000), the American Psychoanalytic Association (2012), the American School Counselor Association (2016), and the National Association of Social Workers (2015). Furthermore, at least 18 professional associations have signed on to the United States Joint Statement Against Conversion Efforts (n.d.), which aims to end SOCE and gender identity change efforts.

The research on SOCE published since APA's (2009) task force report and resolution has continued to support the conclusions that former participants in SOCE look back on those experiences as harmful to them and that there is no evidence of sexual orientation change. The consensus panel that APA conducted for SAMHSA likewise found no credible evidence to support SOCE with children and adolescents and called for an end to SOCE (SAMHSA, 2015). Public opinion has shifted markedly since 2009 as well, showing greater acceptance of sexual and

gender diversity, including LGBTQ+ individuals (Flores, 2014). Thus, an updated policy statement on SOCE from APA supports those who are struggling with the belief that they must or can change their sexual orientation or that parents, guardians, or custodians must or can change their children's sexual orientation to fit with their societal, familial, and institutional membership, and assists the public to understand the conflicts experienced by sexual minority individuals and their families.

An updated policy will also provide more current information to legislators and advocates and dispel the distortions and inaccuracies favored by SOCE proponents (Haldeman, 2018). In nearly half of states (Miller, 2018) and on the federal level (e.g., Therapeutic Fraud Prevention Act, 2017) legislation has been adopted or proposed to prohibit SOCE with minors, to warn consumers that SOCE can be fraudulent, and/or to advise professionals that SOCE are not ethical. SOCE have also been increasingly scrutinized in U.S. legal cases. A New Jersey trial court case (*Ferguson v. JONAH*, 2015) identified a program of SOCE as a form of consumer fraud. Decisions in cases that have challenged ordinances prohibiting licensed mental health professionals from providing SOCE to minors (*Otto v. Boca Raton*, 2019; *Pickup v. Brown*, 2013; *Welch v. Brown*, 2013) have upheld the authority of professional oversight bodies to regulate professional mental health care interactions and to prohibit SOCE by mental health professionals. Persecution of LGBTQ+ people worldwide is an international humanitarian issue, including systematic abuse, imprisonment, and torture. The U.S. field of psychology is influential around the world, and an updated APA policy has the potential to support the rights and safety of LGBTQ+ persons worldwide.

SEXUAL ORIENTATION DIVERSITY IS NORMAL AND HEALTHY

WHEREAS diversity in sexual orientation represents normal human variation (APA, 2009);

WHEREAS there is no scientific basis for regarding any sexual orientation negatively or as a deficit or deviance or result of trauma or parenting (American Psychiatric Association, 2000; APA, 1975; Drescher, 2015; Shidlo & Gonsiorek, 2017); furthermore, sexual behavior with same, other, and more than one gender occurs across species, time, and culture (Bagemihl, 2000; Tskhay & Rule, 2015) and sexual fluidity is normal (Diamond, 2008);

WHEREAS a large percentage of sexual minorities are bisexual rather than exclusively same-gender attracted individuals (Copen, Chandra, & Febo-Vazquez, 2016; Gates, 2011; Pew Research Center, 2013; Savin-Williams, 2017); and SOCE protocols tend to oversimplify, misrepresent, or dismiss bisexuality (Vasey & Rendall, 2003);

WHEREAS stigma related to same-gender attraction, behaviors, and identity (heterosexism) and stigma related to multiple-gender attraction, behaviors, and identity (monosexism) can be internalized by sexual minorities, which can contribute to negative mental health outcomes, such as depression, suicidality, anxiety, and substance use (e.g., American Psychiatric Association, 2000; Barnes & Meyer, 2012; Bostwick, Boyd, Hughes, West, & McCabe, 2014; Herek & McLemore, 2013) as well as negative physical health disparities and outcomes (Fredriksen-Goldsen et al., 2014; Frost, Lehavot, & Meyer, 2015);

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

SOCE REINFORCES SOCIETAL STIGMA FOR SEXUAL MINORITIES

WHEREAS the premise of SOCE is that same-gender attractions are a disorder that requires treatment and that such treatments change sexual orientation, which is contrary to scientific evidence and policies by APA and other mental health organizations (APA, 1998, 2000, 2009);

WHEREAS SOCE locate the source of the problem in the individual rather than within the context of a biased society and ignore the societal contributions to feeling negative about same-gender attraction (Davison, 1976; Herek & McLemore, 2013; Meyer, 2013);

WHEREAS some forms of SOCE are based on negative religious perspectives on sexual orientation that promote bias and prejudice against sexual minorities and APA both "condemns prejudice and discrimination against individuals or groups based on their religious or spiritual beliefs, practices, adherence, or background" and "condemns prejudice directed against individuals or groups, derived from or based on religious or spiritual beliefs" (APA, 2008a; 2008b);

WHEREAS societal ignorance and prejudice about same-gender and multiple-gender sexual orientations have led to personal, family, moral, and religious conflicts and lack of information, which places some sexual minorities at risk for seeking sexual orientation change (Beckstead & Morrow, 2004; Dehlin et al., 2015; Flentje, Heck, & Cochran, 2014; Haldeman, 1994; Hatzenbuehler, Pachankis, & Wolff, 2012; Mallory, Brown, & Conron, 2019; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

WHEREAS SOCE are theoretically associated with stigma; specifically, attempting to change a socially discredited state is theorized as a response to stigma (Goffman, 1963), and seeking SOCE is one component of a valid measure of internalized stigma (Martin & Dean, 1992; Meyer, 2013; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015);

WHEREAS SOCE are empirically associated with stigma; specifically, research evidence supports the relationship between SOCE and constructs associated with stigma, including prejudice (McGeorge, Carlson, & Toomey, 2015), internalized homonegativity (Pachankis et al., 2015; Tozer & Hayes, 2004), and family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan et al., 2018);

WHEREAS SOCE often overlap with other forms of stigma; for example, SOCE proponents have held negative views of sexual minorities and advocated for criminalization of sexual minorities, including in developing countries (Shidlo & Gonsiorek, 2017);

WHEREAS SOCE proponents have held negative views of sexual minorities and advocated for criminalization of sexual minorities (Shidlo & Gonsiorek, 2017) and some transnational efforts to do so have placed sexual and gender minorities at risk of psychological, sociopolitical, and physical harm (Waidzunas, 2015);

WHEREAS the UN HRC (2013; 2015; 2020) categorizes some practices of SOCE as rising to the level of human rights abuse, and these often occur in nations with other anti-LGBTQ+ laws and norms;

WHEREAS youth may be particularly vulnerable because they have been exposed to negative messages about sexual and gender minorities, but they have not developed the resources to cope with these messages (Baams, Dubas, Russell, Buikema, & van Aken, 2018; Rimes, Shivakumar, Ussher, Baker, Rahman, & West, 2019; SAMHSA, 2015);

WHEREAS psychologists are called to oppose stigma and discrimination (APA, 2006a, Conger, 1975), and the Pan-American Health Organization (2012) recommends professional associations "disseminate documents and resolutions…that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation";

WHEREAS APA opposes discrimination against sexual minorities and the adoption of discriminatory legislation and supports the passage of laws and policies protecting the legal rights and freedoms of people of all sexual orientations (APA, 2008a);

SOCE AND RISKS OF HARM

WHEREAS prejudice and minority stress cause adverse mental health and other negative consequences, and SOCE assumptions and interventions reinforce prejudice and sexual minority stress while neglecting education and exploration of affirming sexual-minority options/identities and affiliations (Davison, 1976; Frost et al., 2017; Herek & McLemore, 2013; Meyer, 2013; Ramirez & Galupo, 2019);

WHEREAS sexual minority youth and adults who have undergone SOCE are significantly more likely to experience suicidality and depression than those who have not undergone SOCE (Dehlin, et al., 2015; Ryan et al., 2018); and this elevated risk of suicidality, including multiple suicide attempts, persists when adjusting for other risk factors (Blosnich, et al., 2020; Green, et al., 2020).

WHEREAS research studies using a wide range of designs have found harms associated with SOCE (APA, 2009; Blosnich, Henderson, Coulter, Goldback, & Meyer, 2020; Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015; Green et al., 2020; Ryan et al., 2018), including the following:

- Suicidal behavior and depressive symptoms among youth (Green et al., 2020; Ryan et al., 2018) and adults (Blosnich et al., 2020; Shidlo & Shroeder, 2002); indeed, Green et al. found that SOCE "was the strongest predictor of multiple suicide attempts, even after adjustment for other known risk factors" (p. 1224)
- More mental health problems and lower levels of life satisfaction, social support, educational attainment, and socioeconomic status (Ryan et al., 2018)
- Sexual identity distress (Dehlin et al., 2015)
- Dissociation and emotional numbness, characterized by celibacy, compulsive behaviors, depression, and anxiety (Jacobsen & Wright, 2014; Shidlo & Shroeder, 2002)
- Unprotected anal intercourse with un-tested partners (Shidlo & Shroeder, 2002)
- Substance abuse (Ryan et al., 2018; Shidlo & Shroeder, 2002)
- Disorientation and confusion (Shidlo & Shroeder, 2002; Weiss, Morehouse, Yeager, & Berry, 2010)
- Feelings of inauthenticity in terms of disconnection with parts of themselves (e.g., emotions, thoughts, interests), feeling they would have to choose among parts of themselves, and loss of connection to community (Fjelstrom, 2013)

- Feelings of anger and grief at having lost time and money, and feelings that they were betrayed by mental health professionals (Dehlin et al., 2015; Shidlo & Shroeder, 2002);

WHEREAS for young adults whose parents attempted to change their sexual orientation during adolescence, efforts to send the adolescents to a therapist or religious leader to change their sexual orientation are associated with greater severity of negative outcomes (Ryan et al., 2018);

WHEREAS for many years, professional health associations have deemed SOCE harmful (American Academy of Child and Adolescent Psychiatry, 2018; American Academy of Pediatrics, 1993; American Psychiatric Association, 2000; Australian Psychological Society, 2015; International Society of Psychiatric-Mental Health Nurses, 2008; National Association of Social Workers, 2015; Memorandum of Understanding on Conversion Therapy in the UK, 2017; World Psychiatric Association, 2016);

WHEREAS a consensus of an advisory panel of research and practice experts reviewed professional statements, research, and clinical guidelines, and stated SOCE are "coercive, can be harmful, and should not be part of behavioral health treatment" (SAMHSA, 2015, p.1);

WHEREAS when change in sexual orientation has been reported by participants as a result of SOCE, the scope of reported change has been limited, unreliable, later retracted, and/or not assessed by valid, reproducible methods (APA, 2009):

- Change has been reported only by a limited sample of individuals, who are primarily White/Caucasian, cisgender men who are engaged in conservative religious communities and who aim to be celibate or be in a mixed-gender marriage (e.g., Byrd, Nicolosi, & Potts, 2008; Dehlin et al., 2014; Flentje et al., 2013; Jones & Yarhouse, 2011)

- In numerous cases reports of change have been reversed or retracted (e.g., Retraction notice, 2019; Spitzer; 2012; Weiss et al., 2010)

- Many people did not report change and, in fact, reported elevated distress about the ineffectiveness of SOCE and blamed themselves and/or were blamed for the SOCE failure, despite being "highly motivated" (e.g., Dehlin et al., 2014; Flentje, Heck, & Cochran, 2014; Maccio, 2011; Shidlo & Shroeder, 2002)

- Rather than decrease same-gender attraction, SOCE have been reported to suppress same-gender sexual/romantic behavior (Dehlin et al., 2015; Fjelstrom, 2013; Flentje et al., 2014; Shidlo & Shroeder, 2002)

- Differences in reported sexual attraction and behavior over time can be explained by extant sexual fluidity or bisexuality rather than changes in sexual orientation as a result of SOCE (e.g., Beckstead, 2012; Haldeman, 1994)

- SOCE places individuals at significant risk of serious harm (e.g., depressive symptoms, suicidality, dissociation, substance abuse; Blosnich et al., 2020; Bradshaw et al., 2015; Dehlin et al., 2015; Green et al., 2020; Ryan et al., 2018; Shidlo & Shroeder, 2002)

- Studies have used flawed methodological and statistical approaches that render their conclusions invalid (e.g., APA, 2009; Panozzo, 2013; Retraction notice, 2019; Spitzer, 2012);

WHEREAS participants in SOCE reported self-blame, guilt, shame, negative self-concept, confusion, anxiety, depression, disconnection from family and religious community, and feelings of abandonment by God when their SOCE did not reduce same-gender desire or behavior (Dehlin et al., 2015; Fjelstrom, 2013; Freeman-Coppadge & Horne, 2019; Shidlo & Shroeder, 2002; Super & Jacobson, 2011; Weiss et al., 2010; Wood & Conley, 2014);

WHEREAS a study of a range of methods in which same-gender attracted Latter-day Saints (LDS) church members engaged to help them deal with their sexual orientation found that those who attempted to change their sexual orientation reported all methods to be more harmful and less effective than those who reported other goals, such as understanding or coping with same-gender attraction (Dehlin et al., 2015; cf. APA, 2012 and O'Shaughnessy & Speir, 2018);

WHEREAS reports of harm may be delayed or not reported to SOCE facilitators, even when SOCE participants are experiencing significant harm or distress according to their later reports (Bancroft et al., 2003; Fjelstrom, 2013; Flentje et al., 2013; Shidlo & Schroeder, 2002);

WHEREAS when communicating among themselves, participants who view SOCE as successful ("ex-gays") report similar kinds of harm to that of participants who do not view them as successful ("ex-ex-gays"), such as depression and guilt (Weiss et al., 2010);

WHEREAS many participants report harm from SOCE, including SOCE that draw on otherwise evidence-based practices (e.g., cognitive behavioral therapy) when used to attempt sexual orientation change (Fjelstrom, 2013; Shidlo & Schroeder, 2002);

ETHICAL AND PROFESSIONAL CONCERNS

WHEREAS "psychologists strive to benefit those with whom they work and take care to do no harm" (Principle A, APA, 2017b, p. 3);

WHEREAS "psychologists respect the dignity and worth of all people…" (Principle E, APA, 2017b, p. 4); "psychologists are aware of and respect cultural, individual, and role differences, including those based on… gender, gender identity,… sexual orientation…" and other individual differences (Principle E, APA, 2017b, p. 4).

WHEREAS the APA expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005a, 2006a, 2008b, 2009);

WHEREAS "psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not… engage in fraud, subterfuge, or intentional misrepresentation of fact" (Principle C, APA, 2017b, pp. 3-4); "psychologists do not make false, deceptive, or fraudulent statements concerning… (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; … or (8) their publications or research findings" (Standard 5.01, APA , 2017a, p. 8);

WHEREAS "psychologists' work is based upon established scientific and professional knowledge of the discipline" (Standard 2.04, APA, 2017b, p. 5);

WHEREAS psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b);

WHEREAS minors who have been subjected to SOCE have reported more suicide attempts than those who have not (Green et al., 2020; Ryan et. al., 2018), and these SOCE have been deemed "degrading, inhuman and cruel" creating "a significant risk of torture" by the UN HRC (2020, p. 21);

WHEREAS sexual minority youth are especially vulnerable populations, and those who encounter additional social stigma and inequality, including youth of color and youth from immigrant families, are exposed to multiple forms of prejudice, discrimination, criminalization, family rejection, and loss of support (e.g., Durso & Gates, 2012; O'Donnell, Meyer, & Schwartz, 2011; Ramirez & Galupo, 2019; Ryan et al., 2018);

WHEREAS sexual minority youth are without consistent legal protection from SOCE, and youth as well as their parents, guardians, and custodians need accurate information to make informed decisions regarding their development and well-being (APA, 2009);

WHEREAS the UN HRC (2015) states that "conversion therapy," when forced or otherwise involuntary, can breach the prohibition on torture and ill-treatment, and youth lack adequate legal protection and are particularly vulnerable to involuntary or coercive treatment (APA, 2009; Ryan et al., 2018); the APA states "psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a)" (APA, 2017a, p. 6);

ALTERNATIVES TO SOCE

WHEREAS the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation recommends LGBQ+-affirmative therapeutic interventions for sexual minority adults presenting with an intention to change their sexual orientation to include the following (APA, 2009, 2012; Tozer & Hayes, 2004):

- Acceptance and support
- Comprehensive assessment
- Active coping
- Social support
- Identity exploration and development
- Reduction of internalized stigma;

WHEREAS there is a growing evidence-base for LGBTQ+-affirmative approaches (APA, 2009; Pachankis & Safran, 2019), and LGBTQ+-affirmative approaches have not been associated with harm;

WHEREAS LGBTQ+-affirmative interventions are founded in guidelines of professional practice broadly (e.g., APA, 2006b, 2012, 2017b; Ritter, 2018);

WHEREAS sexual minority youth have benefitted from interventions that utilize LGBTQ+-affirmative approaches in fostering acceptance in family therapy (Diamond, Diamond, Levy, Closs, Ladipo, Siqueland, 2013);

WHEREAS there are ways of reducing distress related to conflicts between sexual orientation and culture/religion that do not have risks of harm and that have promising efficacy (e.g., Chaudoir, Wang, & Pachankis, 2017).

WHEREAS APA's 2005 Policy Statement on Evidence-Based Practice in Psychology defines evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2005b);

BE IT THEREFORE RESOLVED that consistent with the APA definition of evidence-based practice (APA, 2005b), the APA affirms that scientific evidence and clinical experience indicate that SOCE put individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes SOCE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid SOCE;

BE IT FURTHER RESOLVED that after identifying ethical issues (APA, 1998) and empirical problems (APA, 2009) with SOCE, and after reviewing scientific evidence on SOCE published since 2009, the APA affirms SOCE puts individuals at significant risk of harm;

BE IT FURTHER RESOLVED that the APA opposes SOCE because of their association with harm.

BE IT FURTHER RESOLVED that the APA opposes any efforts by mental health professionals that aim at a specific, predetermined sexual orientation or gender-expression outcome or that prescribe a particular sexual orientation or identity;

BE IT FURTHER RESOLVED that, consistent with the APA (2009) Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation and research since that report, the APA urges psychologists to assist patients seeking SOCE to understand the dangers of SOCE, the lack of research showing efficacy, the societal contexts of heterosexism and monosexism, and the internalized stigma that results from these contexts, and to use acceptance, support, comprehensive assessment, active coping, social support, and identity exploration and development, within a culturally competent framework;

BE IT FURTHER RESOLVED that the APA re-affirms that APA (2012) encourages psychologists to use an affirming, multicultural, and evidence-based approach with individuals of all sexual orientations and identities, and to be aware of multiple and intersecting cultural factors, such as those associated with ability, age, class, education, ethnicity, race, and spirituality in conceptualization, treatment, research, and teaching about sexual minorities who are questioning their sexual orientation or experiencing conflict related to sexual orientation;

BE IT FURTHER RESOLVED that the American Psychological Association opposes SOCE because there is abundant evidence of former participants reporting harm resulting from their experiences of SOCE and the contribution that such efforts make to social stigma and prejudice directed at sexual minorities, consistent with other major professional mental health associations, including the Pan-American Health Organization (2012), American Counseling Association (2017), American Academy of Child and Adolescent Psychiatry (2018), American Psychiatric Association (2000), National Association of Social Workers (2015), and World Psychiatric Association (2016);

BE IT FURTHER RESOLVED that the APA opposes training supporting SOCE in any stage of the education of psychologists and psychology;

BE IT FURTHER RESOLVED that APA affirms that same-gender and multiple-gender attraction, feelings, and behavior are normal variations in human sexuality, being LGBTQ+ is not a not mental disorder, and APA opposes portrayals of sexual minorities as mentally ill because of their sexual orientation;

BE IT FURTHER RESOLVED that the APA re-affirms that APA (2012) urges psychologists to acknowledge the diversity and complexities of identities and experiences and describe same-gender and other-gender attractions, behavior, and identities as normal expressions of human sexuality, and that descriptions that rely on stereotypes or describe any sexual orientation as unnatural or bad for one's health perpetuate stigma for sexual and gender minorities and have deleterious mental health consequences;

BE IT FURTHER RESOLVED that the APA opposes any efforts that use nonscientific explanations that stigmatize sexual orientation diversity and efforts that frame same-gender and multiple-gender orientations as unhealthy;

BE IT FURTHER RESOLVED that the APA opposes making claims that sexual attraction can be changed through SOCE;

BE IT FURTHER RESOLVED that the APA opposes distortions of scientific data regarding sexual orientation in policy, judicial proceedings, media, and public opinion;

BE IT FURTHER RESOLVED that the APA opposes dissemination of inaccurate information about the effects of SOCE, such as information that minimizes the evidence of harm from SOCE or information that misconstrues sexual fluidity as an outcome of SOCE;

BE IT FURTHER RESOLVED that the APA opposes dissemination of inaccurate information about sexual orientation, such as the discredited idea that same-gender orientations are caused by negative childhood events or family dysfunction;

BE IT FURTHER RESOLVED that APA encourages the development and dissemination of evidence-based, multiculturally-informed, and LGBTQ+-affirmative educational resources that inform psychologists and the community,

including agencies, organizations, and institutions that provide mental health care, education, or child welfare services, about the harms of SOCE;

BE IT FURTHER RESOLVED that the APA, because of evidence of harm and lack of evidence of efficacy, supports public policies and legislation that oppose, prohibit, or aim to reduce SOCE, heterosexism, and monosexism and that increase support for sexual orientation diversity;

BE IT FURTHER RESOLVED that the APA supports collaboration and partnerships with global, national, and state and local partners to achieve the aims of this resolution.

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