

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

Philip M. Sutton, Ph.D.

Director, International Federation for Therapeutic Choice

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

This information came to our attention when reading a professional statement by the United Kingdom's Association of Christian Counsellors (ACC, 2014) and a news report of this statement in *The Guardian* (Strudwick, 13 January 2014). Both the ACC statement and Guardian report made serious allegations about the great risk for “harm” to persons who receive “reparative or conversion therapy,” what the American Psychological Association (APA) has chosen to call “Sexual Orientation Change Efforts (SOCE)” (APA, 2009). Members of the International Federation for Therapeutic Choice (IFTC), our parent organization, the National Association for Research and Therapy of Homosexuality (NARTH), and like-minded licensed medical and mental health professionals, refer to such therapy as licensed professional care to “change” – i.e., manage, diminish or resolve – unwanted same-sex attractions (SSA) and behavior. Such professional care may include educational guidance, counseling, therapy and/or medical services.

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

Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder ... found 'conversion therapy' *usually* led to worsened mental health, self-harm and suicide attempts...such treatment *routinely* led to worsened (sic) self-harm, thoughts of suicide and suicide attempts (emphasis added).¹

¹ This report was retrieved on 15 January 2014. When attempting to retrieve this report again on 6 February 2014, the link no longer worked. Instead, a report by the same name was retrieved from

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

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

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

1. **First, do no harm. Then do as much good as you can.** Avoiding and minimizing harm (nonmaleficence, nonmalfeasance) and doing good for those one serves (beneficence) are the foundational principles of ethical care by all mental – and medical - health care professionals. As an illustration, the first Principle of the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* (2010) states:

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

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

<http://www.theguardian.com/world/2014/jan/13/christian-therapists-stop-conversion-therapy-turn-gay-patients-straight>. In this revised *Guardian* report, the claims of “harm” due to “conversion therapy” are described as follows: “Research by the US clinical psychologists Ariel Shidlo and Michael Schroeder has shown such treatment routinely led to worsened mental health, self-harm, thoughts of suicide and suicide attempts.”

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

As Rosik (2013c) has written,

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

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

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

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

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

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

Concerning potential harmfulness, *Practice Guideline # 6* states: “***Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.***”

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

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

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

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

Shidlo and Schroeder acknowledge that *how* they conducted their study limits what any reports of “harm” given by the participants in their study may mean. The authors accurately describe their research as an “exploratory study...based on the retrospective accounts of consumers” who are asked to talk about what their therapists did and what the consumers experienced “on average...12 years ago” (p. 250). The authors acknowledge that, like all research using this method, the reports of the alleged consumers’ perspectives on their experience of therapy “may not accurately reflect” what actually happened. Shidlo and Schroeder discuss the potential limitations of the accuracy of the reports of their consumers, in light of the earlier findings of Rhodes, Hill, Thompson, and Elliott (1994) that “retrospective data from clients” are subject to “misunderstandings” about what happened years earlier in psychotherapy. As actual former clients try to make sense of the events of their experience of therapy, they may unknowingly change the details of their story (Rhodes, et al., p. 481).

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

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

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

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

- There is *no* evidence - *besides* the interviewees' claims - that:
 - ❖ They *actually participated* in a “conversion therapy” (SOCE).
 - ❖ They *actually experienced* the harms they claimed to have.
 - ❖ Any actual harm did not preexist their experience of “conversion therapy” (SOCE).
 - ❖ Any actual harm occurred *as a result of, during or after*, the sessions of SOCE, instead of as a result of an experience outside of “therapy.”
- While approximately two-thirds of the “therapists” reported by the presumed former clients were described as “licensed mental health practitioners,” one third of the “therapists” were “unlicensed counselors,” including “peer counselors, religious counselors, and unlicensed therapists.” Shidlo and Schroeder did not clarify what kinds of “harm” were associated with which kind of therapist. This study does not – and cannot based on how it was designed and conducted – show that, if consumers were harmed, this resulted from the actions of licensed mental health professionals who provided “conversion therapy” (i.e., professional SOCE) vs. nonprofessional caregivers.
- Ironically, a careful reading of the report of this study, which admittedly was intended to “document the harm” experienced by consumers of SOCE, also showed the opposite result. In particular, the results suggest that pre-existing suicidality was at least managed, not induced by the participants’ experience of SOCE (Whitehead, 2010, pp. 161-165).

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

Imagine how someone who has experienced a helpful medical or mental health-care product or service would feel, if their product or service were forbidden them based on the kind of information provided by the Shidlo and Schroeder (2002) study. Otherwise satisfied customers would be refused the chance to continue – and willing new consumers to start – receiving these products for services based on complaints – but no clear evidence – of harmful side effects. Those complaining would not have to prove that they actually received the products or treatment

– or that they had used them as directed. The complainers would not have to prove that they actually experienced the side effects they claimed, or that the side effects did not already exist prior to their treatment. Nor, would complainers have to prove who they received the product or service from, while admitting that some of the care providers were professionally licensed, but as many as a third were not.

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

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

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

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

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

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

health services for all personal and interpersonal concerns have this risk *and* (2) that responsible science has not yet shown whether the degree of risk for professional SOCE is greater, the same as, or less than the risk for all other psychotherapies.

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

References

American Psychological Association (2010). *Ethical Principles of Psychologists and Code of Conduct*. Washington, DC: Author. Retrieve from <http://apa.org/ethics/code/index.aspx>

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, D.C.: American Psychological Association. Retrieved from <http://www.apa.org/pi/lgbt/resources/therapeuticresponse.pdf>

Association of Christian Counselors (2014). *An ACC statement to its members January 2014*. Retrieved from <http://www.acc-uk.org/pdfs/ACC%20statement%20to%20its%20members%20January%202014.pdf>.

British Association for Counselling and Psychotherapy (2013). *Ethical Framework for Good Practice in Counselling & Psychotherapy*. Retrieved from http://www.itsgoodtotalk.org.uk/assets/docs/BACP-Ethical-Framework-for-Good-Practice-in-Counselling-and-Psychotherapy_1360076878.pdf

British Medical Association (2010). *Policy group: Annual Representative Meeting, 2010*. Retrieved from <http://web2.bma.org.uk/bmapolicies.nsf/searchresults?OpenForm&Q=conversion+therapy~8~50~Y>

Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention (January, 2014). *Sexually Transmitted Disease Surveillance 2012*. Retrieved from <http://www.cdc.gov/std/stats12/Surv2012.pdf>

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, 9, 329–343. doi:10.1093/clipsy.9.3.329

Jones, S. L., Rosik, C. H., Williams, R. N., & Byrd, A. D. (2010). A Scientific, Conceptual, and Ethical Critique of the Report of the APA Task Force on Sexual Orientation. *The General Psychologist*, 45(2), 7-18. Retrieved from

<http://www.apa.org/divisions/div1/news/fall2010/Fall%202010%20TGP.pdf>

Lambert, M. J., & Ogles, B. M. (2004). *The efficacy and effectiveness of psychotherapy*. New York, NY: Wiley.

Lambert, M. (2013). The efficacy and effectiveness of psychotherapy. In Michael J. Lambert (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th edition), pp. 169-218. Hoboken, NJ: Wiley.

National Association for Research and Therapy of Homosexuality (NARTH) Scientific Advisory Committee (2009). What research shows: NARTH's response to the American Psychological Association's (APA) claims on homosexuality. *Journal of Human Sexuality*, 1, 1-128. Retrieved from <http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1> Summary of *Journal of Human Sexuality Volume 1* retrieved from <http://www.scribd.com/doc/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1>.

National Association for Research and Therapy of Homosexuality, Task Force on Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior (2010). *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior*. *Journal of Human Sexuality*, 2, 5-65. Retrieved from <http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2>). The *Practice Guidelines* themselves may also be retrieved from <http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines>

Pan American Health Organization (17 May 2012). "Cures" for an illness that does not exist. Retrieved from http://www.paho.org/hq/index.php?option=com_content&view=article&id=6803&itemid=1926&lang=en

Phelan, J. E. (2014). *Successful Outcomes of Sexual Orientation Change Efforts (SOCE): An Annotated Bibliography*. Charleston, SC: Practical Application Publications (Phelan Consultants LLC.)

Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding of events. *Journal of Counseling Psychology*, 41, 473-483.

Rosik, C. H. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* Apply its Research Standards Consistently? A Preliminary Examination. *Journal of Human Sexuality*, 4, 70-85. Retrieved from <http://www.scribd.com/doc/174191760/Journal-of-Human-Sexuality-Vol-IV>

Rosik, C. H. (2013a). Countering a One-Sided Representation of Science: NARTH Provides the “Rest of the Story” for Legal Efforts to Challenge Anti-Sexual Orientation Change Efforts (SOCE) Legislation. *Journal of Human Sexuality*, 5, 120-164.

Rosik, C. H. (2013b). Fact- Checking California Senate Bill 1172. *Journal of Human Sexuality*, 5, 94-102. Retrieved from <http://www.narth.com/#!narth-analysis-of-soce-ban/c1q8f>

Rosik, C.H. (2013c). *NARTH Response to the WMA Statement on Natural Variations of Human Sexuality* (December 23, 2013). Retrieved from <http://www.narth.com/#!world-medical-association---narth/c4c6>

Rosik, C.H. (2013d). California Senate Bill 1172: A Scientific and Legislative Travesty—A Look at the Bill’s Misuse of Science. *Journal of Human Sexuality*, 5, 83-93. Retrieved from <http://www.narth.com/#!narth-analysis-of-soce-ban/c1q8f>

Rosik, C. H. (2013d). The (Complete) Lack of a Scientific Basis for Banning Sexual-Orientation Change Efforts (SOCE) with Minors. *Journal of Human Sexuality*, 5, 103-111. Retrieved from <http://www.narth.com/#!narth-analysis-of-soce-ban/c1q8f>

Royal College of Psychiatrists (n.d.), *Psychiatry and LGB People: Psychotherapy and reparative therapy for LGB people*. Retrieved from www.rcpsych.ac.uk/rollofhonour/specialinterestgroups/gaylesbian/submissiontothecofe/psychiatryandlgbpeople.aspx

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer’s report. *Professional Psychology: Research and Practice*, 33(3), 249–259. Retrieved from http://antigayfactcheck.files.wordpress.com/2012/10/changing_so_consumers_report_ashidlo_pprp_2002_249-259.pdf.

Strudwick, P. (2014). Christian counsellors ban therapy aimed at 'converting' gay patients. *The Guardian*, (Monday 13 January 2014). Retrieved from: <http://www.theguardian.com/world/2014/jan/13/christian-therapists-stop-conversion-therapy-turn-gay-patients-straight>

UK Council for Psychotherapy (2010). *UKCP’s Ethical Principles and Codes of Professional Conduct: Guidance on the Practice of Psychological Therapies that Pathologise and/or Seek to Eliminate or Reduce Same Sex Attraction*. Retrieved from <http://www.psychotherapy.org.uk/index.php?id=428>

United Kingdom Parliament. Counsellors and Psychotherapists (Regulation) Bill. Retrieved on 15 Jan 2014 from: <http://www.publications.parliament.uk/pa/bills/cbill/2013-2014/0120/14120.pdf>

Whitehead, N. E. (2010). Homosexuality and Co-Morbidities: Research and Therapeutic Implications. *Journal of Human Sexuality*, 2, 124-175. Retrieved from <http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2>

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

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

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

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

Attitudes Toward Clients Who Seek Change

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

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

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

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

Treatment Considerations

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

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

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

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

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

Education

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

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

As do all professional guidelines, the preceding *Practice Guidelines* were written in order to supplement accepted principles of psychotherapy, not to replace them. As *guidelines*, they are aspirational and intended to facilitate the continued, systematic development of the profession and to help assure a high level of professional practice by clinicians.

The clinical and scientific research which supports each of the *Practice Guidelines* is explained in detail in Volume 2 of NARTH's *Journal of Human Sexuality*. A copy of the complete text of the *Practice Guidelines* with these explanations, and of the entire Volume 2, may be retrieved at:

<http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2> A copy of the

Practice Guidelines themselves may be accessed at :

<http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines>