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My Conversation With a Typical Opponent of Professional Therapies that Include Change

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Abstract

In this article I present in conversational form a hypothetical interaction between myself and a Typical Opponent of Professional Therapies that Include Change (i.e., a Mr. Ty Optic). While hypothetical, this conversation is comprised of responses to common arguments frequently offered by people who are increasingly intent on legally restricting client self-determination and professional speech in the psychological care of unwanted same-sex attractions and behaviors. Through the vehicle of this conversation, I hope to highlight the many difficulties with these arguments, particularly the incomplete or dishonest representation of the scientific record as regards change in same-sex attractions and behaviors and the false caricatures of licensed therapists who do this work. Those who value clients' rights to choose a professional course of care consistent with their moral, religious, and cultural beliefs are encouraged to familiarize themselves with these responses.

Keywords: same-sex attraction change, professional therapy, legal bans

Ty Optic: Christopher, let me start by saying you need to update your perspective. You are clinging to an outdated medical view of homosexuality as some kind of mental disorder or disease that needs to be cured. But only the most rabid flat earth types continue to hold that view, which has been widely discredited by science.

Christopher Rosik: Ty, you seem to be largely talking about a world that existed decades ago for the mental health professions as a whole, but which now is rarely found among even those professionals who work with clients in their pursuit of change in unwanted same-sex attractions and behaviors (SSAB). While it seems plausible to me that homosexuality is a developmental adaptation with multiple pathways arising from certain biological and psychosocial environments, this need not imply that it is a mental disorder. Moreover, you seem to be saying that professional therapy only deals with mental disorders, but this a profound mis-representation. Therapists regularly address issues that are not considered to be mental disorders, such as relationship distress, unplanned pregnancy, or normal grief reactions. Clients with distress about their unwanted SSAB do not come to me with the belief that they have a mental disorder needing a cure, but rather they often report a moral and religious problem.

T.O.: Okay, so you're basically admitting that you are engaging in a religious practice and not a science-based psychotherapy. You should have been a pastor, not a psychologist.

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C.R.: It amazes me how often smart people cannot distinguish between religious motivations and clinical practices. Faith-based values often motivate clients to seek psychological care for unwanted SSAB (as well as therapists to provide that care), but the actual provision of that care for professional therapies that are open to change involves mainstream psychological interventions. The sharing of a faith-based worldview by therapist and client in these instances has many positives (Shumway & Waldo, 2012), though there are risks which can be mitigated by adherence to ethical practice and familiarity with sound science concerning sexual orientation. Most of these clients are simply not going to seek out a gay-affirmative therapist whose moral beliefs about sexuality may be unacceptable to them. So to legally prevent them from exploring change with a licensed therapists is to abandon them to unregulated and too often unaccountable religious counselors, with a plausibly greater risk of harm.

T.O.: Speaking of sound science, haven't the professional associations concluded that homosexuality is a normal and positive variant of sexual expression, so there would be no client distress apart from internalized homophobia and social stigma?

C.R.: The professional associations are making moral and philosophical statements here, not scientific ones. They are blurring the line between science and scientism. Science is simply a methodology, a way of discerning what "is" through empirical research and replication. Scientism is a form of worldview, structured not unlike a religious belief system, which brings certain values and beliefs to the scientific endeavor, and this in turn impacts how findings are interpreted (Auger, 2004; Slife, 2006; Slife & Reber, 2009; Stevenson, 1974). Science as a methodology cannot tell us what should be deemed moral or considered positive (O'Donahue, 1989). This comes from outside of science, and so psychological science does not have a privileged position here, and cannot authoritatively dictate ethics and morality to clients who may not share the value system of social scientists regarding SSAB. Of course, science can tell us if certain beliefs and practices may result in greater emotional and medical distress, which could influence how clients with unwanted SSAB respond to their circumstances. This is where adequate informed consent is always critical. But therapists should not subvert client self-determination and restrict therapeutic options simply because of the presence of distress over unwanted SSAB. Clients often pursue psychological care due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. They should be free to make informed choices about their therapeutic goals that may not quickly allay their presenting distress. This right should not be suspended just because the presenting concern is unwanted SSAB.

T.O.: Look, you can't convince me that the distress of clients with so-called "unwanted" SSAB would even be an issue were it not for a society that discriminates and oppresses them.

C.R.: Then how would you explain those individuals who seek change oriented therapy after having embraced a lesbian, gay, or bisexual (LGB) identity but later found it not satisfying? Look, I agree that historically LGB persons have suffered great injustice. Certainly this has been and remains an issue in understanding the mental health differences between the heterosexual and non-heterosexual populations. But despite the overwhelming popularity of the minority stress theory (Meyer, 2003), research suggests that this provides only a partial explanation for sexual orientation health differences. LGB-related discrimination appears to directly account for less than 9% of the relationship between discrimination (i.e.,

heterosexism) and well-being and discrimination and psychological distress (Schmitt, Branscombe, Postmes, & Garcis, 2014). Frankly, the science is quite far from definitive in this area (Huebner & Perry, 2015; Lick, Durso, & Johnson, 2013; Lick, Durso, & Johnson, 2013; Savin-Williams, 2006). Many variables theoretically linked to health disparities such as social support, identity concealment, and claiming a gay identity may not play a significant role (Denton, Rostosky, & Danner, 2014; Schmitt et al., 2014). Factors that have the most significant relationship to elevated health problems for LGB persons may not be specifically gay-related but similar to those reported by the general population (Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014). And given that studies overwhelmingly are addressing *perceived* discrimination, specific sexual orientation discrimination or stigma may be minimally or unrelated to LGB psychological distress and physical health in the absence of certain intra- or interpersonal processes that might influence or give rise to such perceptions. (Schumm, 2014). Alternatively, LGB lifestyles may be inherently more risky than those of heterosexuals because of certain features of LGB social communities (Prestage et al., 2015; Schumm, 2014; Vrangalova & Savin-Williams, 2014).

T.O.: It sounds to me as if you are blaming the victim.

C.R.: I'm certainly not denying that historically LGB individuals have experienced serious discrimination and victimization. I only want to advocate for a humble scientific stance which acknowledges that there is likely to be much more going on than minority stress, and genuine science should encourage further research with diverse hypotheses rather than let itself be manipulated into the procrustean bed of political agendas. A truly fascinating case in point are those people who are now categorized as "mostly heterosexual." These individuals tend to view themselves and are viewed by others as essentially heterosexual in their sexual orientation and lifestyle and therefore are likely exposed to much less sexual orientation discrimination and stigma than LGB identified persons. Yet it turns out that mostly heterosexual persons appear to be closer to bisexuals than heterosexuals in their health risks (Vrangalova & Savin-Williams, 2014). Finally, there is also the observation that health disparities between heterosexual and non-heterosexual persons appear to be of a roughly similar magnitude even where the cultural environments differ greatly in their acceptance of homosexual practice (de Graaf, Sandfort, & ten Have, 2006; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006). One hopes, often in vain, that these realities would lead to professional, legislative, and judicial restraint concerning efforts to ban the practice of professional care that allows for change in unwanted SSAB. This is especially crucial when such bans are being justified by an alleged causal link between such practice and sexual orientation health disparities.

T.O.: Be that as it may, we do know that attempts to change unwanted SSAB can be harmful, including increased depression and suicide rates among LGB minors. In one study, these youths were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having unprotected sexual intercourse compared to peers whose families were accepting of them. This makes it clear what a health menace such attempts to change unwanted SSAB really are.

C.R.: Ty, you need to dig into the original source material here and not rely on the talking points of activists. It sounds as if you do not know that this study by Ryan and colleagues (Ryan, Huebner, Diaz, & Sanchez, 2009) had nothing to do with therapeutic facilitation of change in unwanted SSAB, even though these statistics are regularly cited to support legal

bans on professional change efforts with minors. Such efforts are simply presumed to be markers of rejection in the complete absence of any empirical justification and the researchers' own caution that cause and effect interpretations should not be made. While families should be encouraged in the strongest terms to love their child regardless of the direction of his or her sexual attractions, the role of family rejection and suicide is a complex one, with one study even finding that LGB individuals who died by suicide had a *lower* incidence of family conflict (5.7%) than their heterosexual counter parts (17.1%) (Skerrett, Kolves, & De Leo, 2014). Such findings argue in favor of conducting more research to further understand this issue, not emotional overreactions that misuse scientific findings in order to restrict client rights and threaten professional vocations.

T.O.: I've read about some more recent research that proves these therapies to change SSAB cause a lot of harm. What about them?

C.R.: You are correct that there have been a few recent studies that appear to show a significant risk of harm (Bradshaw, Dehlin, Crowell, & Bradshaw, 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Flentje, Heck, & Cochran, 2013). However, they suffer from some of the same methodological problems that the oft-cited Shidlo and Schroeder (2002) study evidenced (Rosik, 2014). For example, they oversampled people who felt harmed, were religiously disaffected, or who identified as formerly ex-gay. In addition, many of the care providers were religious counselors, not licensed therapists. Utilizing this research to evaluate change-oriented therapies makes no more sense than interviewing a sample of former marital therapy patients who had subsequently divorced to determine the effectiveness and harm of marital therapy in general.

T.O.: But shouldn't even the potential for harm argue in favor of forbidding such practices, especially when they have not been shown to be effective?

C.R.: Regarding accusation of harm, there is plenty of evidence of the "potential for harm" for psychotherapy in general, with 5-10% of adults and 15-24% of minors getting worse from their treatments (Lambert, 2013; Lambert & Ogles, 2004). So claims of potential harm simply cannot be offered as an indictment of therapies allowing for change in unwanted SSAB unless opponents can marshal evidence that the prevalence of harm specific to professionally assisted change efforts is greater than it is for all forms of psychotherapy, and no such data currently exist. As the American Psychological Association (APA, 2009, p. 42) acknowledged in its review of the scientific literature, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" [sexual orientation change efforts].

T.O.: And what about the question of whether these practices actually work?

C.R.: More than 100 years of experiential evidence, clinical studies, and research has demonstrated that it is possible for some men and women to experience change in SSAB and that therapeutic work may facilitate these shifts (Karten & Wade, 2010; Phelan, Whitehead, & Sutton, 2009; Santero, Whithead, & Ballestero, 2016; Spitzer, 2003). This research is not above critique, of course, as is the case with all research, but critics of this literature seem to view the presence of any study limitations as justification for complete dismissal of the findings. You will notice that opponents have a much higher standard for methodological rigor when it comes to efficacy of change interventions than they do when addressing the potential for harm, as was the case with the APA (2009) Task Force Report (Jones, Rosik, Williams, & Byrd, 2010). They demand randomized, controlled research designs to

prove efficacy and reject case studies of success, but are quick to tout anecdotal accounts of harm in the absence of any controlled, representative research showing harm. This is in spite of the APA's (2009) conclusion that, "Recent SOCE (sexual orientation change efforts) research cannot provide conclusions regarding efficacy or safety" (p. 3). It's been years now since I and some colleagues have invited anyone in the APA to do collaborative work with us to address the issues of efficacy and harm (Rosik, Jones, & Byrd, 2012), but we have not had a single hint of interest. This makes me question the sincerity of opponents' demands for us to conduct the most methodologically rigorous forms of research, especially when many of these same folks are working to create a professional and legal environment completely hostile to the conducting of such studies. One can't be faulted for wondering why anybody would want to conduct any sort of research on a subject that is caught in the legal and ethical crosshairs of politicians and the mental health associations.

T.O.: But people are born gay, so it can't be possible for them to change who they really are.

C.R.: Many people confuse the issues of volition and cause. Although choice appears to be a factor for some people, especially bisexuals (Herek, Norton, Allen, & Sims, 2010), most people do not experience their non-heterosexuality as a conscious decision. Because of this, people often assume that sexual orientation must be biologically determined. And while biology plays a role in every variety of human behavior, this does not eliminate an important role for human agency in the choices people make in what they do with their SSAB and how such choices influence the manner and degree of its ultimate expression. To put it in more prosaic terms, the biology creates a tendency, not a tyranny. Ty, here's a question for you: If one member of an identical twin pair has same-sex attractions (SSA), what percentage of co-twins will also have SSA?

T.O.: I can't say that I know exactly, but it must be pretty high.

C.R.: Well actually, the largest and most rigorous studies of identical twins suggest that if one identical twin has SSA, the co-twin will also have SSA only about 11% for men and 14% for women (Bailey, Dunne, & Martin, 2000; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010). This may be among the lowest twin concordance rates for any behavioral trait ever measured and it means that factors the twins have in common, such as genes and upbringing, are mostly not responsible for the SSA. Even the APA has backtracked from an earlier position that biology plays a significant role in SSA (APA, 1998) and has more recently acknowledged that no single factor or set of factors is known to definitively determine SSA (APA, 2008).

T.O.: Well, even if there isn't a gay gene, that doesn't mean SSAB can change.

C.R.: If you define change as being a simple choice or as the complete elimination of all same-sex attractions for all time, then I would agree with your skepticism. However, if you take the more nuanced understanding of change as occurring on a continuum of change in response to an ongoing dedication to certain emotional, behavioral, and relational practices, then it is very reasonable to conclude that some individuals do experience change that is meaningful and satisfying for them. The same twin studies I noted previously seem to indicate that changes in sexual orientation are more difficult to achieve than changes in depression or personality, but more likely than achieving long-term change in weight loss or criminality (Turkheimer, 2011). This data should prevent coarse and absolute claims of people either "having a choice" or being "hard wired" for their traits, including sexual orientation. Of

course, such nuance is not convenient for the activists and sadly this can result in the compromising of science for political purposes.

T.O.: Okay, perhaps I'll grant you that a few people may say they have experienced some sort of change, but a few rare occurrences surely doesn't change the equation for the overwhelming majority of people who have SSAB. Since so few actually experience any change, I still think it makes sense to prohibit these practices.

C.R.: Again, I think you are misinformed about the frequency of change. While research directly addressing therapeutically assisted change in SSAB is limited, there is a growing research literature on sexual orientation fluidity that must inform this discussion (Diamond, 2008; Dickson, Paul, & Hebiison, 2003; Dickson, van Roode, Cameron, Paul, 2010; Far, Diamond, & Boker, 2014; Mock & Eiback, 2010). One large study of adolescents found that 98% of 16 and 17 year-olds experiencing same-sex attractions shifted to experiencing greater opposite sex attractions just one year later (Savin-Williams, Joyner, & Rieger, 2012; Savin-Williams & Ream, 2007; Whitehead & Whitehead, 2014). Large numbers of young nonheterosexual women and (to a slightly lesser extent) nonheterosexual men report fluidity in their sexual attractions and identities (Katz-Wise, 2015; Katz-Wise & Hyde, 2015), which typically begins before the age of 18. I find it especially of interest that men who had experienced fluidity believed sexuality was changeable much more than men who did not experience fluidity, who tended to believe that sexuality was something a person is born with. This raises the possibility many non-heterosexual male activists who fight against a client's right to pursue professional care for unwanted SSAB are men who have not experienced change and who assume that this the case for all non-heterosexuals. Therefore they may erroneously assume that all claims of change must either be lies or self-deception.

T.O.: But even if this change can occur, what does that have to do with psychotherapy? Don't most of these people indicate that they felt no control over their changes?

C.R.: Sure, you are correct that what these studies appear to document is spontaneous change that is often not experienced as a volitional process, though it can be influenced by relational and environmental contexts (Manley, Diamond, & van Anders, 2015). Nonetheless, the discovery of SSAB fluidity to such an extent certainly makes more plausible claims that professional psychological care has contributed to such change for some people. To quote one research group, "People with changing sexual attractions may be reassured to know that these are common rather than atypical" (Dickson et al., 2013, p. p. 762). The fact is that many adolescents and young adults with SSA are already shifting toward greater opposite-sex attractions. This raises serious doubts about how dangerous professional psychotherapy really is for people who wish to therapeutically facilitate what may be for them a naturally occurring process of SSAB change. With such changes in SSAB occurring all around us, is it reasonable to maintain that the only place where such change can never happen is in the therapist's office?

T.O.: I don't know. From what I've heard, it still seems a stretch to me that so called "reparative therapy" or "conversion therapy" could ever help anyone.

C.R.: Well, let me ask you, what do you think goes on in such therapies?

T.O.: You know, quite a number of abominable things. Therapists like you determine the client's goals and coerce people into pursuing change. I don't know if you do this, but it seems that many of your colleagues are utilizing abusive aversive techniques, such as

shocking people's genitals or using chemicals to induce nausea while clients look at gay porn. They tell their clients they must have been sexually abused. I've heard claims that some of these therapists even tell people God hates them and they may even recommend exorcisms.

C.R.: Ty, I hear this sort of description all the time. It tells me that you really don't have a clue what modern professional therapy for unwanted SSAB is. Please rely less on the gay activists' blogs for your information. I am pleased to be able to inform you that none of those practices are a part of professional psychological care for unwanted SSAB. Aversive approaches have not been utilized for a long time by the psychological profession, even among those licensed therapists who would entertain a client's request to pursue modification of their SSAB. My colleagues and I always follow the lead of the client in goal setting because we understand that there is no genuine therapeutic process without client self-determination. Nor do we assume every client has a history of childhood sexual abuse, although there is reason from the literature to believe such abuse can be an important influence on the development of SSAB for some people (Beard et al. 2013; Bickham et al. 2007; O'Keefe et al. 2014; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2009; Fields, Malebranche, & Feist-Price, 2008). Consider the testimony of one participant in a study of the effects of rape upon a non-clinical sample of men: "Before the assault I was straight; however, since the assault I have begun to engage in voluntary homosexual activity. This causes me a great deal of distress as I feel I am not really homosexual but I cannot stop myself having sex with men. I feel as if having sex with men I am punishing myself for letting the assault happen in the first place" (Walker, Archer, & Davies, 2005, p. 76).

Finally, I for one assure questioning clients of God's love for them and would never recommend exorcisms as a therapeutic intervention. You described an all-too-frequent caricature of these therapies, which would be laughable were it not given credence by so many uninformed people. All of these extremely poor practices you mention, were they actually being used by licensed therapists, would surely result in their loss of licensure under *existing* state laws and regulations. Yet I am not aware of a single therapist who has had to deal with an ethics complaint on such a basis. Bans on professional therapies that allow for change are therefore unnecessary. And what's worse, such laws may leave clients who desire to pursue change feeling abandoned by their therapists and could create serious legal peril for therapists should changes occur in client SSA even when such changes are not a focus of intervention. Ty, these bans are in practice not really bans on therapy at all but rather aimed at outlawing a particular therapeutic *goal*—a client's goal to pursue change. Legally prohibiting change-allowing therapy is simply not possible because, in point of fact, there is no one special kind of therapy for such clients. Therapists who work in this area typically utilize a number of mainstream interventions that address emotional and cognitive processes as well as certain relational dynamics. While many of these therapists operate from a psychodynamic and developmental perspective, they often incorporate insights from the cognitive, interpersonal, narrative, and psychodrama traditions as well, to name just a few (Hamilton & Henry, 2009).

T.O.: Well, if this approach to therapy is so effective, why have so many ex-gay leaders fallen or renounced these practices?

C.R.: I think "many" is an overstatement. What you need to know, however, is that most of these leaders operated in religious contexts, which sometimes contributed to unrealistic expectations for complete change and to feeling pressure to portray such change when this was

not their experience. Equally critical to recognize is that many of these "ex-ex-gays" never received any professional therapy with a licensed therapist knowledgeable about change in unwanted SSAB. While many individuals find valuable emotional and spiritual support in ministry contexts outside of professional therapy and research indicates that some experience meaningful and significant shifts in their SSAB (Jones and Yarhouse, 2011), this may not always be the case. That some ex-gay organizations may have over promised change or used unconventional techniques suggests that these organizations would benefit from resources that accurately describe what is scientifically known and not known about sexual orientation and SSAB change (see, for example, www.therapeuticchoice.com).

T.O.: I think this is wishful thinking. I think all of these so called ex-gays really just don't want to acknowledge that they are gay, that their efforts to change have failed, and the failure of their leaders who claimed to have experienced change in SSAB is the smoking gun.

C.R.: Ty, I don't recommend relying on such overgeneralizations. It could really backfire on you. I mean, I would find it contemptible if someone argued that because some highly influential gay rights leaders have recently been fighting charges of felony sodomy and sexual abuse with teenage boys (Manning, 2014; Mayes, 2015a, 2015b; Willson & Jaquiss, 2015) and felony possession of child pornography (Ho, 2014) that this must be the case for all such leaders. In a similar vein, you can't possibly be an expert on everyone's experience of SSAB change. It just makes you look desperate to win a point when you leave the scientific record and engage in such overgeneralizations.

T.O.: Well, what about Spitzer's renunciation of his own study on change that you and others like you are still citing to suggest change occurs? Doesn't that qualify as being part of the scientific record?

C.R.: You are mistaken in characterizing Spitzer action as a renunciation of his study (Spitzer, 2003; 2012). He simply decided to reinterpret his findings in what many suspect was a response to pressure from colleagues and activists, a belief that some had misused the study, and a concern for his legacy. In fact, the editor of the prestigious journal where the study was published refused to retract the article, stating that there was no basis for such an action and that the research was sound (Dreger, 2012). So Spitzer simply changed his interpretation, which left many of his participants feeling betrayed (Armelli, Moose, Paulk, & Phelan, 2013). The self-report nature of the study, common to most psychological research, can't *prove* SSAB change. But unless one postulates initial and ongoing self-deception and fabrication by participants to an incredulous degree, Spitzer's study still has something to contribute regarding the possibility of change in SSAB. Moreover, if you are going to reject a study simply because it utilized participant self-reports, then to be consistent you would have to question the validity of most psychological research.

T.O.: But there is more than Spitzer. Haven't virtually all the mental health and medical associations opposed the practice of attempting to change sexual orientation? That seems to me to be an insurmountable argument against such practices.

C.R.: On the face of it, yes, that does sound like the trump card, which is why opponents typically pile on the references to statements by professional associations against such therapies in their arguments. But by looking a little deeper, it's evident things are not that simple. The fact of the matter is that there is little to no ideological diversity in the leadership of these organizations, leading to a left-of-center groupthink process when addressing

contentious social issues, including those involving sexual orientation (Duarte et al., in press; Redding, 2001; 2012; 2013; Wright & Cummings, 2005). This has an inhibitory influence on the production of diverse scholarship in areas such as SSAB change that might run counter to preferred worldviews and advocacy interests.

T.O.: Now you're starting to sound like some sort of wacko conspiracy theorist. Do you have even a shred of evidence for these claims?

C.R.: There is no need to manufacture some sort of conspiracy here. This is just what naturally occurs when the leaders of mental health associations all share the same basic values and worldview. Since you asked, allow me to give you a few examples that speak to the issue. I'll bet that you didn't know that in 2011 the American Psychological Association's leadership body—the Council of Representatives—voted 157-0 to support same-sex marriage (Jayson, 2011). Likewise, the leadership of the National Association of Social Workers endorsed a total of 169 federal candidates in the 2014 elections—all of whom were affiliated with the Democratic Party (Pace, 2014). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011). Even the esteemed American Medical Association has been hemorrhaging membership due to supporting left-of-center programs like Obamacare and now represents less than 20% of physicians in America (Pipes, 2011). With statistics such as these, sensible people will take the pronouncements of these associations regarding therapy assisted SSAB change with a huge grain of salt.

T.O.: And why is that? What does this have to do with your misguided therapy?

C.R.: A lot, actually. Consider for example that while many qualified conservative psychologists were nominated to serve on the highly influential APA (2009) Task Force that reviewed the scientific literature on change oriented therapies, all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). To no one's surprise, only psychologists unsympathetic to change-allowing therapies were appointed—and at least 5 of the 6 Task Force members were LGB identified. It appears that the APA operated with a litmus test when considering Task Force membership—the only views of homosexuality that were tolerated were those the APA deemed acceptable. Of course the APA has every right to stack the deck however they wish on such matters, but they should at least publicly acknowledge that they represent a firmly and consistently left-of-center take on the science and politics of sexual orientation. It's worth noting that such practices have occurred in other arenas within the APA, most recently with revelations about the collusion of high ranking APA leaders and the U. S. Department of Defense to bend the ethical rules and allow psychologists to participate in enhanced interrogations (i.e., torture) (Ackerman, 2015; Risen, 2015). An APA Presidential Task Force was appointed to weigh in on the ethical issues in 2005, and 6 of the 10 Task Force members had ties to the defense or intelligence communities, thereby compromising their objectivity on the matter. Such manipulation was intended to curry continued favor with and benefits from the Department of Defense for the profession of psychology, and its exposure further highlights the intractably political dimension of the APA.

T.O.: All right, I'm really getting tired of this discussion. Frankly, I don't really care about your arguments. I just know in my heart that what you and others like you are trying to do is wrong and should be stopped. Nothing is going to change my mind about that.

C.R.: Okay, Ty. I do appreciate your honesty. I have to say your dismissal of scientific findings you don't like sounds a lot like the Ninth Circuit Court of Appeals majority

opinion that upheld the constitutionality of California's law preventing minors from talking to licensed therapists in a manner that could be construed as promoting change in SSAB. Preferring politics over science, Judge Graber opined, "And we need not decide whether SOCE actually causes 'serious harms'; it is enough that it could 'reasonably be conceived to be true by the governmental decisions makers.'" Ty, you are of course free to go on believing what you want to believe, though I do hope our conversation might help you realize there actually are good people doing this work and doing it with some real basis in the social science research literature. At any rate, I thank you for giving me an opportunity to express my views. I do hope that will continue.

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