THE AMERICAN PSYCHOLOGICAL ASSOCIATION SAYS BORN-THAT-WAY-AND-CAN'T-CHANGE IS NOT TRUE OF SEXUAL ORIENTATION AND GENDER IDENTITY

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In its "Series Preface," the *APA Handbook on Sexuality and Psychology* (American Psychological Association, 2014) states,

> With the imprimatur of the largest scientific and professional organization representing psychology in the United States and the largest association of psychologists in the world, and with content edited and authored by some of its most respected members, the *APA Handbooks in Psychology* series will be the indispensable and authoritative reference resource to turn to for researchers, instructors, practitioners, and field leaders alike. (p. xvi).

The American Psychological Association (APA) could not confer any higher authority on the *APA Handbook of Sexuality and Psychology* than it does, bestowing its "imprimatur" and calling it "authoritative." In the *APA Handbook*, *the American Psychological Association itself* is now saying that born-that-way-and-can't-change is *not* true.

In addition, Dr. Lisa Diamond, a self-avowed lesbian, is co-editor-in-chief of the *Handbook*, and she authors and co-authors chapters in it. She qualifies as one of the APA's "most respected members." In her *APA Handbook chapters where she is speaking for the APA itself,* in her own book, in a YouTube lecture, and journal articles (example 2016) she says sexual orientation does not come in two types —exclusively homosexual and exclusively heterosexual—that are rigid and unchangeable. She is telling LGBT activists to stop promoting the myth.

The jury is in, and it says "born that way and can't change" is not true. The public deserves to hear this correction.

In the *APA Handbook,* thus on behalf of the APA, Dr. Diamond states, "Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally (v. 1, p. 633). Most people who experience same-sex attraction also already experience opposite-sex attraction.

More conventional wisdom that the *APA Handbook* says is not true is that same-sex attraction and transgender identity never change. The American Psychological Association (2011) officially recognizes sexual fluidity or sexual orientation change. The *APA*

Handbook says, “Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation” (Rosario & Schrimshaw, 2014, *APA Handbook*, v. 1, p. 562).

Also, both the American Psychiatric Association (*Diagnostic and Statistical Manual-Fifth Edition*, p. 455) and the American Psychological Association (Bockting, 2014, *APA Handbook*, v. 1, p. 744) recognize transgender identity fluctuates, and the vast majority of gender dysphoric minors will eventually accept their chromosomal sex.

Therapy that is open to change is more in harmony with the course of sexual orientation and gender identity for many than is gay-affirmative or transgender-affirmative therapy.

Researchers often measure sexual orientation by one or more of three separate factors: sexual attraction, behavior, and self-label identity. The *APA Handbook* says these frequently do not match within the same individual (Rosario & Schrimshaw, 2014, v. 1, pp. 558-559; Diamond, 2014, v. 1, p. 634). For example, a person could have bisexual attraction, homosexual behavior, and heterosexual identity if there is a sense that the same-sex sexuality does not represent the authentic self. Many do not act on or base their identity on their same-sex attractions (Rosario & Schrimshaw, 2014, p. 559; Diamond, 2014, p. 629-630; both in *APA Handbook*, v. 1). The APA *Handbook* states, “[R]esearch on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or [orientation] identities over time” (Diamond, 2014, in *APA Handbook*, v. 1, p. 636).

The *APA Handbook* reviews a highly regarded study by gay researcher Savin-Williams and colleagues (Savin-Williams, Joyner, & Rieger, 2012; Rosario & Schrimshaw, 2014, *APA Handbook*, v. 1, p. 562) that followed the sexual *identity* of young adult participants when most were ages 18 through 24 and again at ages 24 through 34, about 6 years later. Participants indicated whether their sexual identity was heterosexual, mostly heterosexual, bisexual, mostly homosexual, or homosexual.

The largest identity group, second only to heterosexual, was “mostly heterosexual” for each sex and across both age groups, and that group was “larger than all the other non-heterosexual identities combined” (Savin-Williams et al., 2012, abstract).

“The bisexual category was the most unstable” with *three quarters* changing that status *in 6 years* (abstract, emphasis added). “*[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality”* (p 106, emphasis added). Diamond and Rosky say similar change is found in other population-based longitudinal studies, and rates of change do not appear to decline as participants get older (2016, p. 7, Table 1).

For both sexes, a heterosexual sexual orientation identity was the most stable” (Savin-Williams 2012, p. 104), as Diamond reports is true in all of the large-scale prospective, longitudinal studies (2014, in *APA Handbook*, v. 1, p. 637). Savin-Williams and colleagues reported, “In our study, when shifts occurred in sexual orientation identity, most were to an adjacent identity category” (Savin-Williams, 2012, p. 107). Spontaneous

change from a 100% homosexual identity to a 100% heterosexual identity seldom occurred (p. 109). “When mostly heterosexual women and men shifted over time it was primarily to and from the 100% heterosexual category” (p. 109).

A shift of one or more adjacent categories in the direction toward heterosexuality can make a desired goal of chastity easier for some, and a goal of having a gender complimentary relationship may become more or entirely possible.

In the *APA Handbook,* Diamond says, “In every large-scale representative study reviewed thus far, the single largest group of individuals with same-sex attractions report predominant—but not exclusive—other-sex attractions” (v. 1, p. 634). Kleinplatz and Diamond say (*v.1, p. 256)*, “Historically such individuals [mostly heterosexual] have been treated with skepticism and suspicion by laypeople and scientists alike. They have been viewed as either closeted lesbian, gay, or bisexual individuals (who cling to a mostly heterosexual label to avoid the stigma associated with same-sex sexuality) or as confused or questioning “heteroflexibles.” *Heteroflexibles* refers to individuals who, given our culture, have had infrequent same-sex fantasies or experimented with same-sex behavior but are not really gay or bisexual (v.1, p. 256). Kleinplatz and Diamond urge that “it *is critically important for clinicians not to assume that any experience of same-sex desire or behavior is a sign of latent homosexuality and instead to allow individuals to determine for themselves the role of same-sex sexuality in their lives and identity”* (p. 257) (emphasis added).

Mostly heterosexual individuals do not identify as LGB, and LGB activists have not recognized or represented them well. Some have had therapists simply assume they are really homosexual and would be happier leaving their marriage and family for a gay life. But some mostly heterosexual individuals want therapy to help them be faithful in their marriages and keep their families intact. Therapy that is open to change is more harmonious with the heterosexual fluidity tendency of bisexual and mostly heterosexual individuals—most non-heterosexuals—than is gay-affirmative therapy.

Readers can hear Dr. Diamond review research in her YouTube lecture for an LGBT audience at Cornell University (2014). She said that excellent and abundant research has now *established* that sexual orientation—including attraction, behavior, and identity self label—all three—is fluid for both adolescents and adults and for both genders, and exceptions for LGB individuals are a minority.

Despite the research, political activists continue to promote the “born-that-way-and-can’t-change” myth about sexual orientation. The Southern Poverty Law Center (SPLC) published a paper in May this year (2016) in which it said the “National Gay and Lesbian Task Force reacted with alarm,” and “warned that the ex-gay industry was under-mining the battle for LGBT rights by suggesting that homosexuality is a choice, not an unchangeable condition like skin color” (p. 9). Actually, it is the APA and Dr. Diamond, herself a gay activist, that are undermining the falsehood that sexual orientation is like skin color.

According to the *APA Handbook*, "[W}e are far from identifying potential genes that may explain not just male homosexuality but also female homosexuality" (Rosario & Scrimshaw 2014, v. 1, p. 579). The *Handbook* also says it is not the case that some same-sex sexuality is biologically determined and some is not. "The inconvenient reality….is that social behaviors are always jointly determined" by nature, nurture, and opportunity (Kleinplatz & Diamond 2014, *APA Handbook*, v. 1, pp. 256-257).

At the same time, the APA (2008) says same-sex attraction is generally not a choice. Therapists who are open to change agree people generally do not just choose their sexual attractions, otherwise these therapists would not bother to offer therapy. But the reality is, non-heterosexual sexual orientation is changing all around us.

Further underscoring that sexual orientation is changeable, Diamond reports that some say choice was involved for them, and she says one may choose a context or circumstance that may influence sexual orientation change, such as choice of roommate (2008, pp. 249-250), deciding to live in an ideological, political, or social reference group —as in "political lesbians" (2014, in *APA Handbook*, v.1, p. 632), or being in therapy that is open to change (2008, p. 252). One may reasonably deduce that LGBT and traditional religious support groups are diverse social reference groups that may bring out sexual attraction potential and influence fluidity in contrasting directions.

Dr. Diamond tells LGBT activists near the end of her YouTube lecture, "I feel as a community, the queers have to stop saying, 'Please help us. We're born this way, and we can't change' as an argument for legal standing. I don't think we need that argument, and that argument is going to bite us in the ass, because now we know that there's enough data out there, that the other side is aware of as much as we are aware of it." In other words, Dr. Diamond says, "Stop saying 'born that way and can't change' for political purposes, because the other side knows it's not true as much as we do."

She also directly discussed the harm of political activists promoting the "can't change" myth in her own book on sexual fluidity in women (2008, pp. 256-257) that won the Distinguished Book Award from the APA Division 44 (LGBT). She acknowledged that, for political motives, some activists "keep propagating a deterministic model: sexual minorities are born that way and can never be otherwise." She addresses the question, "[I]s it really so bad that it is inaccurate?" Her answer is, "Over the long term, yes, particularly because women are systematically disenfranchised by this approach." She said this deceptive practice does harm to women who have experienced sexual attraction fluidity and have "thought there was something wrong with them." She said this "silencing is ironic," because it is being inflicted by the modern lesbian/gay/bisexual rights movement.

Dr. Diamond has publicly gone on record that she opposes psychotherapy that is open to sexual attraction change. (See Rosik, 2016 for a penetrating critique of her position as expressed in Diamond & Rosky, 2016. See Rosik) Nevertheless, she says in her book (2008, p. 252) that some same-sex attracted individuals may have more capacity than others to channel the direction of their sexual fluidity in response to their context, and they may for that reason modify it in psychotherapy.

Officially, the *APA Handbook* predictably affirms the position of an APA Task Force (2009) that “same-sex attractions, behavior, and partnerships" are “normal variations in human sexuality and explicitly condemns the use of therapeutic techniques aimed at changing an individual’s sexual orientation” (Mustanski, Kuper, and Greene, 2014, *APA Handbook*, p. 598).

What is surprising is that the APA, in its 2014 *Handbook,* is now not consistent in the view that sexual variation is normal. The *APA Handbook* confirms there is excellent research evidence for “associative or potentially causal links” between childhood sexual abuse and ever having same-sex partners, especially for some men. (Mustanski, Kuper, & Greene, 2014, pp. 609-610).

It also confirms that there is possible evidence that psychopathology may be related to the development of transgender identity (Bockting, 2014, *APA Handbook*, v.1, p).

If pathology leads to an individual’s sexual variation, treatment could lead to a significant and meaningful shift in that variation for some. It is harmful and ineffective to ban such treatment.

Curiously, the APA has been silent on even stronger research showing that growing up without one or both biological parents, especially the parent who is the same sex as the child, is potentially causally related to having same-sex attraction, relationships, or identity (Frisch & Hviid, 2006; Francis, 2008; Udry & Chantala, 2005). If literal unavailability of parents could have such effects for some individuals, do we want to dismiss lightly the possibility that emotional unavailability of parents, and especially the parent of the same sex as the child, could have similar effects for some?

In the most stunning of these studies, research on a population cohort of two million Danes (Frisch & Hviid 2006) found that, not only loss of a parent, but specifically loss of the same-sex parent in childhood (such as through death, divorce, end of parent cohabitation, not living with the same-sex parent, or unknown paternity), and especially parent loss during the first six years of life and, for girls, the mother’s death during adolescence, were associated with greater likelihood of entering same-sex marriage. The findings suggest the most important developmental periods for parent influence on sexual orientation may be the first six years of life and adolescence. The researchers concluded, “Our study provides population-based, prospective evidence that childhood family experiences are important determinants of heterosexual and homosexual marriage decisions in adulthood” (p. 533).

In the United States, a large, nationally representative, prospective longitudinal study (using the first two waves of the highly regarded Nationally Longitudinal Study of Adolescent Health (Ad Health) data set) found a female growing up with only a biological father—that is, without a biological mother—increased the likelihood a female identified herself as not exclusively heterosexual by 9.5 percentage points (Francis 2008 p. 376).

In another study using the Ad Health data set (the first three waves), when same-sex and opposite-sex attraction were measured separately, 90% of boys who had strong

same-sex interest had absent fathers—a very strong relationship. Among boys, the greater the degree of same-sex attraction, the greater the likelihood of father absence, delinquency, and suicidal thoughts. As opposite sex interest also rose, that strong relationship completely disappeared (Udry & Chantala, 2005, p. 487). With the father's presence, there was likely to be opposite-sex attraction, possibly with same-sex attraction also.

There is evidence that environmental factors are causes of gender identity, and transgender identity can be pathological. The *APA Handbook* says the origin of transgender identity is "most likely the result of a complex interaction between biological and environmental factors….Research on the influence of family of origin dynamics has found some support for separation anxiety among gender-nonconforming boys and psychopathology among mothers" (Bockting, 2014, v. 1, p. 743, emphasis added). The World Professional Association for Transgender Health (WPATH) says in its "Standards of Care" that gender dysphoria may be "secondary to and better explained by other diagnoses" (2011, p. 24). The Endocrine Society, with its 6 co-sponsors, says in its Clinical Practice Guideline "that gender identity and/or gender expression likely reflect a complex interplay of biological, environmental, and cultural factors" (p. 6).

The American Psychiatric Association, the American Psychological Association, and the Endocrine Society with its 6 co-sponsoring organizations that include WPATH concur that it is not the case that individuals with transgender identity are born that way and can't change. According to the *APA Handbook* (Bockting 2014, v. 1, p. 744), 75% or more of gender dysphoric boys and girls accept their chromosomal sex by adolescence or adulthood. According to the American Psychiatric Association's *Diagnostic and Statistical Manual, Fifth Edition (DSM-5)*, as many as 70 to 98% of gender dysphoric boys and as many as 50 to 88% of gender dysphoric girls eventually accept their chromosomal sex (calculated from DSM-5, p. 455). The Endocrine Society, with 6 co-sponsoring associations, in its "Clinical Practice Guideline" places that figure at about 85% (2017, p. 11). (See Zucker's answer to critiques, 2018).

Further, Bockting says in the *APA Handbook*, "Premature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role, such as registering a birth-assigned boy in school as a girl) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development." If there is early social transition, "the stress associated with possible reversal of this decision has been shown to be substantial…" (2014, in APA Handbook, p. 744). The Endocrine Society with its 6 co-sponsoring organizations agrees that "social transition…has been found to contribute to the likelihood of persistence" (2017, p. 11).

The American Psychological Association, in its *Handbook* (Bockting, 2014, v. 1, pp. 750-751), and the American Psychiatric Association (*DSM-5*, p. 455) say there are three approaches to treatment: attempts to lessen the dysphoria and nonconformity, attempts to get the environment—family, school, and community—to fully accept the child's gender-variant identity, and the wait-and-see ap-

proach. The *APA Handbook* warns that the full acceptance approach "runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist" (Bockting, 2014, v. 1, p. 750).

Both gender identity and sexual orientation can change, psychopathology may be a developmental factor in both, and therefore, we can reasonably deduce, some individuals, though not all, may make a significant and meaningful change in sexual orientation or gender identity through therapy. Therapy that is open to change does not directly seek to change sexual or gender variations. Rather, as underlying issues are treated with ethical mainstream and evidence-based methods used in clinics around the world, these variations often diminish or change as a by-product.

For a review of over a century of research on therapy that is open to sexual orientation change, including research published in APA peer-reviewed journals by APA members (Phelan, Whitehead & Sutton, 2009) go to: Report Summary: https://www.scribd.com/document/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1. Full report: https://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1. See testimonies of change through psychotherapy here: voicesofchange.net.

Therapy that is open to sexual variation change should be neither coerced nor banned. Shaming generally should be avoided by family members or others for an individual's sexual variation or for the outcome of therapy, whether change does not occur or does occur in the heterosexual direction. Ex-gays have been subjected to shaming, sometimes by the LGBT community that rightfully decries shaming.

Some who have modified their sexual variation with the assistance of professional psychotherapy have regretted that their culture or family told them they could not and should not try to change through therapy. Some chose to live in ideological reference groups that supported chastity or change toward heterosexuality.

Individuals who have sexual variations should have the right to know the above information and to seek therapy to address such issues.

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