ALLIANCE DEFENSE FUND
Defending Our First Liberty

February 13, 2008

Via email and UPS Next Day Air

President Brian Canfield
American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304

Dear President Canfield:

My name is Brian W. Raum and I am an attorney with the Alliance Defense Fund ("ADF"). The ADF is a not-for-profit legal alliance which is committed to defending religious liberty and professional freedom of conscience. I am writing on behalf of our client Dr. Warren Throckmorton to express our concerns about the ACA's position regarding sexual identity therapy. Specifically, the ACA has indicated that counselors who engage in or refer clients for "conversion therapy" are in danger of violating the ACA's ethical rules.

In a 2006 ethics committee memorandum (attachment 1) the ACA suggests that "conversion therapy" has no legitimate place in counseling and that those who either engage in such counseling or refer clients for this kind of therapy may violate the ACA's ethics rules. As part of its analysis, the ACA ethics committee presumes that this kind of counseling is based on a belief that homosexuality is a disorder and that because the mental health professions have concluded otherwise, there is no legitimate basis for such counseling. The memorandum also presumes that all sexual identity therapy is aimed at "conversion" and is exclusively religious in nature ("[c]onversion therapy as a practice is a religious, not psychologically based, practice.").

The ACA's approach fails to appreciate that there is a significant population of individuals who experience their same-sex attraction as inconsistent with their deeply held religious beliefs or as otherwise inconsistent with their core values. While some desire to alter their sexual attractions, others elect to change their sexual *practices* to harmonize with their religious beliefs. Still others seek to change their religious beliefs so as to integrate their same-sex attractions and behavior with their faith.

It is imperative that the religious beliefs of both clients and counselors are respected and protected. A client's religious beliefs and desire to conform his or her sexual practices to those beliefs should be respected and should not be intentionally undermined by a counselor. Moreover, the ACA should not maintain ethical opinions which effectively exclude counselors who maintain sincerely held religious beliefs regarding human sexuality. In some cases, it may be necessary for a counselor to refer a client so as to not violate the counselor's own conscience (e.g. referring a client who wants to continue to engage same-sex relationships). In the same

way, a counselor who believes it is appropriate to engage in "gay affirming" therapy should be able to freely refer a client not wishing to affirm homosexual desire or behavior to a counselor who will work within the client's value framework.

Moreover, it appears to us that the ACA's stance is at odds with existing ACA policy in that the ACA Ethics Committee opinion assumes a consensus about sexuality that does not exist. According to ACA policy 301.7, the Association may not take sides on social issues where there is no consensus. Certainly, there is no consensus regarding the social and policy issues raised when clients experience value conflicts surrounding their same-sex attractions. Policy 301.7 states:

> Policy and Role on Non-Consensus Social Issues of Conscience
>
> Having respect for the individual's values and integrity in no way restricts us as individuals from finding legitimate avenues to express and support our views to others, who decide and make policy around these issues. To this end, it will be ACA Governing Council policy to encourage its members to find and use every legitimate means to examine, discuss, and share their views on such matters within the Association. We also endorse the member's right to support social, political, religious, and professional actions groups whose values and positions on such issues are congruent with their own. Through such affiliations, every member has an opportunity to participate in shaping of government policies which guide public action.
>
> To truly celebrate our diversity, we must be united in our respect for the differences in our membership. To this end, the role of the Association in such matters is to support the rights of members to hold contrary points of views, to provide forums for developing understanding and consensus building, and to maintain equal status and respect for all members and groups within the organization.
>
> Following this philosophy, the Governing Council considers it inappropriate for this body to officially take sides on issues which transcend professional identity and membership affiliation, and which substantially divide our membership, at least until such time that there can be a visible consensus produced among the membership.
>
> Approved: 7/15/90

We believe the ACA's Ethics Committee opinion puts the ACA at odds with this policy and we join with Dr. Throckmorton and other counselors to bring this to your attention. The ACA Ethics Committee opinion provides no guidance or recognition that counselors may work with clients who do not affirm homosexual behavior in order to pursue lives in keeping with their religious beliefs and values.

The American Psychological Association's Council of Representatives passed a resolution in August of 2007 (attachment 2) in which it emphasized the importance of "understanding and respecting patient/client spirituality and religiosity . . . in conducting culturally-sensitive research, psychological assessment and treatment." Because of the reality that many individuals have emotional and psychological conflicts with their same-sex attractions based on their religious convictions, the psychological community must be free to address these issues without fear of reprimand.

The ACA's division concerned with religious and values issues promotes competencies which specify that competent counselors include and integrate their religious views into counseling. Three of the competencies are particularly relevant:

- Competency 7: The professional counselor can assess the relevance of the religious and/or spiritual domains in the client's therapeutic issues.

- Competency 8: The professional counselor is sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client.

- Competency 9: The professional counselor uses a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference (Association for Spiritual, Ethical, Religious & Values Issues in Counseling, n.d.).

It is of the utmost importance that professionals maintain freedom of conscience as they discharge their duties to clients. As it stands, the ACA's policy regarding "conversion therapy" or other forms of sexual identity therapy is unclear, may result in adverse consequences for counselors at the state licensing level, and could have insurance and professional liability ramifications. The ADF is therefore committed to defending the rights of counselors who engage in, or refer clients for, sexual identity therapy. Therefore, we seek clarification regarding the ACA's policy and believe such clarification is necessary to avoid future legal action.

Sincerely,

Brian W. Raum
Senior Legal Counsel

ATTACHMENT 1

ACA In The News

Contact:
Debra Bass
703-823-9800, x243

Ethical issues related to conversion or reparative therapy

(News) 05.22.06

By Joy S. Whitman, Harriet L. Glosoff, Michael M. Kocet and Vilia Tarvydas

American Counseling Association members have consulted ACA staff and leaders regarding the practice of conversion therapy and the 2005 Code of Ethics. For this reason, the ACA Ethics Committee is sharing its formal interpretation of specific sections of the ACA Code of Ethics concerning the practice of conversion therapy and the ethics of referring clients for this practice.

Committee members individually considered a hypothetical scenario that was based on actual questions posed to the members and staff. The Ethics Committee then met to reach a consensus opinion.

The scenario

During the third session of counseling, a client reports that he is gay and states, "I want to change my way of life and not be gay anymore. It's not just that I don't want to act on my sexual attraction to men. I don't want to be attracted to them at all except for as friends. I want to change my life so I can get married to a woman and have children with her." At the suggestion of a friend, the client has read about reparative/conversion therapy and has researched this approach on the Internet. He is convinced this is the route he wants to take.

The counselor listens carefully to what the client has to say, asks appropriate questions and engages in a clinically appropriate discussion. The counselor informs the client that, although she is happy to continue working with him, she does not believe reparative/conversion therapy is effective and no empirical support exists for the approach. She further states that this form of therapy can actually be harmful to clients, so she will not offer this as a treatment. The client says he is disappointed that the counselor will not honor his wishes. He then asks for a referral to another counselor or therapist who will work with him to "change his sexual orientation."

Interpretation

The ACA Ethics Committee considered many factors and derived a consensus opinion that addresses several sections of the ACA Code of Ethics and moral principles of practice present in such a scenario. We started with the basic goal of reparative/conversion therapy, which is to change an individual's sexual orientation from homosexual to heterosexual. Counselors who conduct this type of therapy view same-sex attractions and behaviors as abnormal and unnatural and, therefore, in need of "curing." The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA.

The ACA Governing Council passed a resolution in 1998 with respect to sexual orientation and mental health. This resolution specifically notes that ACA opposes portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation. In addition, the resolution supports dissemination of accurate information about sexual orientation, mental health and appropriate interventions and instructs counselors to "report research accurately and in a manner that minimizes the possibility that results will be misleading" (ACA Code of Ethics, 1995, Section G.3.b). In 1999, the Governing Council adopted a statement "opposing the promotion of reparative therapy as a cure for individuals who are homosexual." In fact, according to the DSM-IV-TR, homosexuality is not a mental disorder in need of being changed. With this in mind, we have a difficult time discussing the appropriateness of conversion therapy as a treatment plan. Regardless, there are clients who seek out counselors in hopes of changing their sexual behaviors, orientation or identity, so the ACA Ethics Committee conducted a review of the literature on reparative therapy.

We found that the majority of studies on this topic have been expository in nature. We found no scientific evidence published in psychological peer-reviewed journals that conversion therapy is effective in changing an individual's sexual orientation from same-sex attractions to opposite-sex attractions. Further, we did not find any longitudinal studies conducted to follow the outcomes for those individuals who have engaged in this type of treatment. We did conclude that research published in peer-reviewed counseling journals indicates that conversion therapies may harm clients (refer to the full article posted on the ACA website for references).

These findings bring several questions to the forefront:

- Is a counseling professional who offers conversion therapy practicing ethically?
- Since ACA has taken the position that it does not endorse reparative therapy as a viable treatment option, is it ethical to refer a client to someone who does engage in conversion therapy?
- If a client insists on obtaining a referral, what guidelines can a counselor follow?
- If professional counselors do engage in conversion therapy, what must they include in their disclosure statements and informed consent documents?

Ethics Committee members agreed that it is of primary importance to respect a client's autonomy to request a referral for a service not offered by a counselor. In the 2005 ACA Code of Ethics, Standard A.11.b. ("Inability to Assist Clients") states, "If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives." Additionally, Standard D.1.a. ("Different Approaches") reminds us that "counselors are respectful of approaches to counseling services that differ from their own."

Standard A.1.a. ("Primary Responsibility"), however, states that "the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." Referring a client to a counselor who engages in a treatment modality not endorsed by the profession and that may, in fact, cause harm does not promote the welfare of clients and is a dubious position ethically. This position is supported by Standard A.4.a. ("Avoiding Harm"), which says, "Counselors act to avoid harming their clients, trainees and research participants and to minimize or to remedy unavoidable or unanticipated harm."

Professionals also engage in treatment only after appropriate educational and clinical training and do not practice outside of their areas of competence (Standard C.2.a., "Boundaries of Competence"). This standard clearly states that "counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience." In addition, per Standard C.2.b. ("New Specialty Areas of Practice"), "Counselors practice in specialty areas new to them only after appropriate education, training and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm." Therefore, any professional engaging in conversion therapy must have received appropriate training in such a treatment modality with the requisite supervision. There is, however, no professional training condoned by ACA or other prominent mental health associations that would prepare counselors to provide conversion therapy.

In addition, requests by clients seeking to change their sexual orientation should be understood within a cultural context. Standard E.5.c. ("Historical and Social Prejudices in the Diagnosis of Pathology") requires that "counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment." Historically, the mental health professions viewed homosexuality as a mental disorder. But in 1973, homosexuality was removed from the Diagnostic and Statistical Manual as a mental disorder. However, within various religious and cultural communities, same-sex attractions and behaviors are still viewed as pathological. Yet the professional communities of counseling and psychology no longer diagnose a client who has attractions to people of the same sex as mentally disordered. To refer a client to someone who engages in conversion therapy communicates to the client that his/her same-sex attractions and behaviors are disordered and, therefore, need to be changed. This contradicts the dictates of the 2005 ACA Code of Ethics.

Clients may ask for a specific treatment from a counseling professional because they have heard about it from either their religious community or from popular culture. A counselor, however, only provides treatment that is scientifically indicated to be effective or has a theoretical framework supported by the profession. Otherwise, counselors inform clients that the treatment is "unproven" or "developing" and provide an explanation of the "potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm" (Standard C.6.e., "Scientific Bases for Treatment Modalities").

Considering all the above deliberation, the ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if

they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients (also see Standard A.2.b., "Types of Information Needed"). This information also must be included in written informed consent material by those counselors who offer conversion therapy despite ACA's position and the Ethics Committee's statement in opposition to the treatment. To do otherwise violates the spirit and specifics of the ACA Code of Ethics.

Informing clients about conversion therapy

So what do ethical counselors do if clients state they are still interested in pursuing a referral for a counselor who offers conversion therapy? We advise professional counselors to discuss the potential harm of this therapy noted in evidence-based literature from scholarly publications in a manner that respects the client's decision to seek it. This again relates to Standard A.1.a. ("Primary Responsibility") and Standard A.4.b. ("Personal Values"), which requires counselors to be "aware of their own values, attitudes, beliefs and behaviors and avoid imposing values that are inconsistent with counseling goals." The responsibility of counseling professionals at this juncture is to help clients make the most appropriate choices for themselves without the counselor imposing her/his values. To do so respects a client's request and leaves open the possibility that the client can return to the professional counselor if the conversion therapy is ineffective and harms the client.

Again, Ethics Committee members agree that ethical practitioners refer clients seeking conversion therapy only under the conditions previously discussed. Further, it is imperative that counselors provide clients seeking conversion therapy with information about this form of treatment, including what types of information clients should expect from referral counselors. The following must be included in informed consent material and communicated to clients seeking referral:

1. Conversion therapy assumes that a person who has same-sex attractions and behaviors is mentally disordered and that this belief contradicts positions held by the American Counseling Association and other mental health and biomedical professional organizations. Additionally, the ACA passed a resolution in 1999 stating that it does not endorse reparative therapy as a "cure" for homosexuality. Any professional who engages in conversion therapy is not offering the professional standard of care and would need to include that he or she is offering it not as a professional counselor but is providing counseling within the scope of practice of some other profession (i.e., Christian counselor).
2. Conversion therapy as a practice is a religious, not psychologically-based, practice. The premise of the treatment is to change a client's sexual orientation. The treatment may include techniques based in Christian faith-based methods such as the use of "testimonials, mentoring, prayer, Bible readings, and Christian weekend workshops" (Shroeder & Shidlo, 2001, p. 150). It may also use cognitive-behavioral techniques such as aversion therapy (i.e.; stopping clients from masturbating to same-sex images; encouraging imagery of getting AIDS paired to same-sex arousal), reinforcement techniques that emphasize traditional gender role behavior (i.e., for men to "engage in team sports, to go the gym, and to attend Promise Keepers" and for women "to learn how to cook, sew, and apply make-up"; Shroeder & Shidlo, 2001, p. 149), and use of sexual surrogates. However, there is no training offered or condoned by the American Counseling Association to educate and prepare a professional counselor wishing to engage in this type of treatment.
3. Research does not support conversion therapy as an effective treatment modality. There have been "no objective screening criteria, no consensus about outcome measurement, and no blinded or side-by-side studies" (Forstein, 2001, p. 173) and there is "no article in a peer reviewed scientific journal" stating that conversion therapy alters someone's sexual orientation (p. 177). The results of some research indicate that some clients seeking this treatment do change their behavior approximately 30% of the time, but the same clients report changing only their behaviors but not their sexual orientation. This is an important distinction to share with clients, helping them understand the difference between behaviors and sexual identity. Further, no long-term studies have been conducted to discern whether research participants who reported a change in their behaviors maintained these changes over time.
4. There is potential for harm when clients participate in conversion therapy. Results of studies indicate that there are clients who enter this type of treatment and then report that they function more poorly than when they entered (Nicolosi, Byrd, & Potts, 2000; Schroeder & Shidlo, 2001).
5. There are treatments endorsed by the Association for Gay, Lesbian, and Bisexual Issues in Counseling (see http://www.aglbic.org/resources/competencies.html), a division of the American Counseling Association and the American Psychological Association (see http://www.apa.org/pi/lgbc/guidelines.html) that have been successful in helping clients with their sexual orientation. These treatments are gay affirmative and help a client reconcile his/her same-sex attractions with religious beliefs

In summary, if clients still decide that they wish to seek conversion therapy as a form of treatment, counselors should also help clients understand what types of information they should seek from any practitioner who does engage in conversion therapy. The Committee members agree that counselors who offer conversion therapy are providing "treatment that has no empirical or scientific foundation" (ACA, 2005, C.6.e.) and, therefore, must "must define the techniques/procedures as 'unproven' or 'developing' and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm" (ACA, C.6.e.). Additionally, any client seeking treatment is entitled to complete information about the treatment. This is consistent with A.2.b (Types of Information Needed) that state "counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information." Counselors who do not include this information would be considered by the Committee to be in violation of the ACA Code of Ethics.

There also was agreement among the Committee members that any counselors stating that they can offer conversion therapy must also offer referrals to gay, lesbian, and bisexual-affirmative counselors and should discuss thoroughly the right of clients to seek these professionals' counsel. In doing so, counselors must explore with clients the underlying reasons for their interest in changing their sexual orientation and discuss the social, political, and religious influences that underpin homophobia that may be harming the client.

Counselor Education

Finally, in addition to educating potential clients about conversion therapy, the members of the Ethics Committee agreed that counselor education training programs must also adhere to section F.6.f (Innovative Theories and Techniques), which states that "when counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as 'unproven' or 'developing' and explain to students the potential risks and ethical considerations of using such techniques/procedures." A similar approach to informed consent for clients seeking conversion therapy must be upheld when discussing this treatment with counseling students.

References

American Counseling Association (2005). Code of ethics. Alexandria, VA: Author.
American Counseling Association (1995). Code of ethics. Alexandria, VA: Author.
Association for Gay, Lesbian, and Bisexual Issues in Counseling. (n.d.). Competencies for counseling gay, lesbian, bisexual and transgendered (GLBT) clients. Retrieved February 7, 2006, from http://www.aglbic.org/resources/competencies.html.
American Psychological Association. (1998). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. Retrieved February 7, 2006, from http://www.apa.org/divisions/div44/guidelines.htm
Forstein., M. (2001). Overview of ethical and research issues in sexual orientation therapy. Journal of Gay and Lesbian Psychotherapy, 5(3/4), 167-179.
Nicolosi, J., Byrd, A. D. & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. Psychological Reports, 86, 1071-1088.
Shroeder, M., & Shidlo, A. (2001). Ethical issues in sexual orientation conversion therapies: An empirical study of consumers. Journal of Gay and Lesbian Psychotherapy, 5(3/4), 131-166.

ATTACHMENT 2

Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice

Adopted by APA Council of Representatives, August, 16 2007

Introduction

Prejudice based on or derived from religion and antireligious prejudice has been, and continues to be, a cause of significant suffering in the human condition. The American Psychological Association's policy statement on prejudice, stereotypes, and discrimination provides operational definitions for prejudices, stereotypes, and interpersonal and institutional discrimination. The resolution specifically states,

> Prejudices are unfavorable affective reactions to or evaluations of groups and their members, stereotypes are generalized beliefs about groups and their members, interpersonal discrimination is differential treatment by individuals toward some groups and their members relative to other groups and their members, and institutional discrimination involves policies and contexts that create, enact, reify, and maintain inequality. (American Psychological Association Council of Representatives, 2006)

Prejudice directed against individuals and groups based on their religious or spiritual beliefs, practice, adherence, identification, or affiliation has resulted in a wide range of discriminatory practices. Such discrimination has been carried out by individuals, by groups, and by governments. Examples of nongovernmental discrimination based on religion include social ostracism against individuals based on their religion, desecration of religious buildings or sites, and violence or other hate crimes targeted toward adherents of particular faith traditions (U.S. Department of State, 2004). Prejudice and discrimination based on religion and/or spirituality continue to be problematic even in countries that otherwise have achieved a high level of religious liberty and pluralism. Governmental discrimination based on religion has taken both covert and overt forms. Current examples of covert religious discrimination include government surveillance of religious speech, pejorative labeling by governmental bodies of certain religious groups as "cults" with a resulting loss of religious freedoms, and a lack of legal protection for citizens from nonmajority faiths who are victims of religious hate crimes (Center for Religious Freedom, 2001, 2003; U.S. Department of State, 2004). Prejudice based on or derived from religion has been used to justify discrimination, prejudice, and human rights violations against those holding different religious beliefs, those who profess no religious beliefs, individuals of various ethnicities, women, those who are not exclusively heterosexual, and other individuals and groups depending on perceived theological justification or imperative.

Indeed, it is a paradoxical feature of these kinds of prejudices that religion can be both target and victim of prejudice, as well as construed as justification and imperative for prejudice. The right of persons to practice their religion or faith does not and cannot entail a right to harm others or to undermine the public good. This situation is further complicated by the increasing tendency of individuals to identify as "spiritual" apart from any identification or affiliation with a religious tradition (Hill & Pargament, 2003). It is as yet unclear what impact on the relationships between spirituality and prejudice this increasing trend toward noninstitutionalized spirituality may produce.

While many individuals and groups have been victims of antireligious discrimination, religion itself has also been the source of a wide range of beliefs about and attitudes and behaviors toward other individuals (Donahue & Nielsen, 2005). Several decades of psychological research have found complicated relationships between measures of religiousness and measures of prejudice (Allport, 1954/1979; Allport & Ross, 1967; Gorsuch & Aleshire, 1974; Spilka, Hood, Hunsberger, & Gorsuch, 2003). Dozens of studies have reported positive linear relationships between measures of conventional religiousness, such as frequency of church attendance or fundamentalism scale elevations, and measures of negative social attitudes, such as prejudice, dogmatism, or authoritarianism (Altemeyer, 1988; Altemeyer & Hunsberger, 1992, 2005). Yet, Allport (1950) and his colleagues (Allport & Ross, 1967) observed that the relationship between religion and prejudice is curvilinear rather than linear, with highly religious individuals having lower levels of prejudice than marginally religious adherents. This finding has been relatively robust over numerous subsequent studies on religion and prejudice using self-

report measures (Batson & Stocks, 2005; Gorsuch & Aleshire, 1974). Recent research, using non-self-report measures, has found even more complex and varied sets of relationships between diverse types of personal religiousness and prejudice indicators (Batson & Stocks, 2005). As Allport (1954/1979) concluded, "The role of religion is paradoxical. It makes prejudice and it unmakes prejudice" (p. 444). While religious motivations and rationales for violent conflicts, social oppression of religious outgroups or norm violators, and the reinforcement of prejudicial stereotypes are readily adducible, it is also true that religious motivations and rationales have been key factors contributing to prosocial developments such as the abolition of slavery (Harvey, 2000; Herek, 1987; Hunsberger, 1996; Rambo, 1993; Rodriguez & Ouellete, 2000; Silberman, 2005; Stark, 2003). This complex relationship between religion and psychosocial variables has led to multiple models of the relationship between forms of religiousness and psychological adjustment (Allport, 1950; Altemeyer, 2003; Batson, Schoenrade, & Ventis, 1993; Kirkpatrick, 2005; Watson et al., 2003). A common motif across these models is that it is the way one is religious rather than merely whether one is religious that is determinative of psychosocial outcomes (Donahue, 1985).

It is important for psychology as a behavioral science, and various faith traditions as theological systems, to acknowledge and respect their profoundly different methodological, epistemological, historical, theoretical, and philosophical bases. Psychology has no legitimate function in arbitrating matters of faith and theology, and faith traditions have no legitimate place arbitrating behavioral or other sciences. While both traditions may arrive at public policy perspectives operating out of their own traditions, the bases for these perspectives are substantially different.

WHEREAS religion is an important influence in the lives of the vast majority of people, is ubiquitous in human cultures, and is becoming increasingly diverse throughout the world (Brown, 2005; Eck, 2001; Genia, 2000; Richards & Bergin, 2000; Shafranske, 1996); and

WHEREAS the American Psychological Association opposes prejudice and discrimination based upon age, race, ethnicity, religion, sexual orientation, gender, gender identity, or physical condition (American Psychological Association, 2002); and

WHEREAS, psychologists respect the dignity and worth of all people and are committed to improving the condition of individuals, organizations, and society; and psychologists are aware of and respect cultural, individual, and role differences among individuals, including (but not limited to) those based on ethnicity, national origin, and religion (American Psychological Association, 2002); and

WHEREAS the American Psychological Association has recognized the profound negative psychological consequences of hate crimes motivated by prejudice (American Psychological Association Council of Representatives, 2005), and

WHEREAS prejudice against individuals and groups based on their religion or spirituality, and prejudice based on or derived from religion, continues to result in various forms of harmful discrimination perpetuated by private individuals, social groups, and governments in both covert and overt forms (Balakian, 2004; Center for Religious Freedom, 2001, 2003; Marshall, 2000; U.S. Department of State, 2004; Yakovlev, 2004); and

WHEREAS the experience of pluralistic cultures that embrace religious liberty shows that a variety of religious faiths and nonreligious worldviews can peacefully coexist while maintaining substantial doctrinal, valuative, behavioral, and organizational differences (Byrd, 2002; Eck, 2001; Marshall, 2000); and

WHEREAS understanding and respecting patient/client spirituality and religiosity are important in conducting culturally sensitive research, psychological assessment, and treatment (Hathaway, Scott, & Garver, 2004; McCullough, 1999; Richards & Bergin, 1997; Shafranske, 1996; Worthington & Sandage, 2001); and

WHEREAS evidence exists that religious and spiritual factors are underexamined in psychological research both in terms of their prevalence within various research populations and in terms of their

possible relevance as influential variables (Emmons & Paloutzian, 2003; Hill & Pargament, 2003; King & Boyatzis, 2004; Miller & Thoresen, 2003, Weaver et al., 1998); and

WHEREAS contemporary psychology as well as religious and spiritual traditions all address the human condition, they often do so from distinct presuppositions, approaches to knowledge, and social roles and contexts, and while these differences can be enriching and may stimulate fruitful interaction between these domains, they also can present opportunities for misunderstanding and tension around areas of shared concern (Emmons & Paloutzian, 2003; Gould, 2002; Haldeman, 2004; Miller & Delaney, 2004; Van Leeuwen, 1982); and

WHEREAS religion and spirituality can promote beliefs, attitudes, values, and behaviors that can dramatically impact human life in ways that are either enhancing or diminishing of the well-being of individuals or groups (Allport, 1950; Altemeyer & Hunsberger, 1992, 2005; Silberman, 2005; Stark, 2003);

THEREFORE BE IT RESOLVED that the American Psychological Association condemns prejudice and discrimination against individuals or groups based on their religious or spiritual beliefs, practices, adherence, or background.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association condemns prejudice directed against individuals or groups, derived from or based on religious or spiritual beliefs.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association takes a leadership role in opposing discrimination based on or derived from religion or spirituality and encouraging commensurate consideration of religion and spirituality as diversity variables.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association encourages all psychologists to act to eliminate discrimination based on or derived from religion and spirituality.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association encourages actions that promote religious and spiritual tolerance, liberty, and respect, in all arenas in which psychologists work and practice, and in society at large.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association views no religious, faith, or spiritual tradition, or lack of tradition, as more deserving of protection than another and that the American Psychological Association gives no preference to any particular religious or spiritual conventions.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association will include information on prejudice and discrimination based on religion and spirituality in its multicultural and diversity training material and activities.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association encourages the dissemination of relevant empirical findings about the psychological correlates of religious/spiritual beliefs, attitudes, and behaviors to concerned stakeholders with full sensitivity to the profound differences between psychology and religion/spirituality.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association encourages individuals and groups to work against any potential adverse psychological consequences to themselves, others, or society that might arise from religious or spiritual attitudes, practices, or policies.

THEREFORE BE IT FURTHER RESOLVED that psychologists are encouraged to be mindful of their distinct disciplinary and professional roles when approaching issues of shared concern with religious adherents.

THEREFORE BE IT FURTHER RESOLVED that psychologists are encouraged to recognize that it is outside the role and expertise of psychologists as psychologists to adjudicate religious or spiritual tenets,

while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist. Those operating out of religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing that they can appropriately speak to theological implications of psychological science.

THEREFORE BE IT FURTHER RESOLVED that psychologists are careful 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.

THEREFORE BE IT FURTHER RESOLVED that the American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles.

References

Allport, G. W. (1950). *The individual and his religion*. New York: Macmillan.

Allport, G. W. (1979). *The nature of prejudice*. Reading, MA: Addison-Wesley. (Original work published 1954)

Allport, G. W., & Ross, M. J. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 5*, 432–443.

Altemeyer, B. (1988). *Enemies of freedom: Understanding right-wing authoritarianism*. San Francisco: Jossey-Bass.

Altemeyer, B. (2003). Why do religious fundamentalists tend to be prejudiced? *International Journal for the Psychology of Religion, 13*, 17–28.

Altemeyer, B., & Hunsberger, B. (1992). Authoritarianism, religious fundamentalism, quest, and prejudice. *International Journal for the Psychology of Religion, 2*, 113–133.

Altemeyer, B., & Hunsberger, B. (2005). Fundamentalism and authoritarianism. In R. F. Paloutizian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 378–393). New York: Guilford.

American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.

American Psychological Association Council of Representatives. (2005). *Resolution on hate crimes*. Washington, DC: Author.

American Psychological Association Council of Representatives. (2006). *Resolution on prejudice, stereotypes, and discrimination*. Washington, DC: Author.

Balakian, P. (2004). *Burning Tigris, the Armenian genocide and America's response*. New York: HarperCollins.

Batson, C. D., Schoenrade, P., & Ventis, W. L. (1993). Religion and the individual: A social-psychological perspective. New York: Oxford University Press.

Batson, C. D., & Stocks, C. L. (2005). Religion and prejudice. In J. F. Davidio, P. Glick, & L. A. Rudman (Eds.), *On the nature of prejudice: Fifty years after Allport* (pp. 413–427). Malden, MA: Blackwell.

Brown, K. (2005). Does psychology of religion exist? *European Psychologist, 10,* 71–73.

Byrd, J. P., Jr. (2002). *The challenges of Roger Williams: Religious liberty, violent persecution and the Bible*. Macon, GA: Mercer University Press.

Center for Religious Freedom. (2001). *Massacre at the millennium: A report on the murder of 21 Christians in Al-Kosheh, Egypt in January 2000 and the failure of justice*. Washington, DC: Author.

Center for Religious Freedom. (2003). *The rise of Hindu extremism and repression of Christian and Muslim minorities in India*. Washington, DC: Author.

Day, D. (1997). *Loaves & fishes: A history of the Catholic Workers Movement.* Maryknoll, NY: Orbis Books.

Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology, 48*, 400–419.

Donahue, M. J., & Nielsen, M. E. (2005). Religion, attitudes, and social behavior. In R. F. Paloutizian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 274–291). New York: Guilford Press.

Eck, D. L. (2001). *A new religious America: How a "Christian country" has become the world's most religiously diverse nation*. San Francisco: Harper.
Emmons, R. A., & Paloutzian, R. F. (2003). The psychology of religion. *Annual Review of Psychology, 54*, 377–402.
Genia, V. (2000). Religious issues in secularly based psychotherapy. *Counseling and Values, 44,* 213–222.
Gorsuch, R. L., & Aleshire, D. (1974). Christian faith and ethnic prejudice: A review and interpretation of research. *Journal for the Scientific Study of Religion, 28*, 348–354.
Gould, S. J. (2002). *Rock of ages: Science and religion in the fullness of life.* New York: Ballantine Books.
Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *Counseling Psychologist , 32,* 691–715.
Harvey, P. (2000). *An introduction to Buddhist ethics*. New York: Cambridge University Press.
Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35*, 97–104.
Herek, G. M. (1987). Religious orientation and prejudice: A comparison of racial and sexual attitudes. *Personality and Social Psychology Bulletin, 13*, 33–44.
Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*, 64–74.
Hunsberger, B. (1996). Religious fundamentalism, right-wing authoritarianism, and hostility towards homosexuals in non-Christian religious groups. *International Journal for the Psychology of Religion, 6*, 39–49.
King, P. E., & Boyatzis, C. J. (2004). Exploring adolescent spiritual and religious development: Current and future theoretical and empirical perspectives. *Applied Developmental Science, 8*, 2–6.
Kirkpatrick, L. A. (2005). Evolutionary psychology: An emerging new foundation for the psychology of religion. In R. F. Paloutizian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 101–119). New York: Guilford Press.
Marshall, P. (2000). *Religious freedom in the world: A global report on freedom and persecution*. Nashville, TN: Broadman & Holman.
McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology, 46,* 92–98.
Miller, W. R., & Delaney, H. D. (2004). Psychology as the science of human nature: Reflections and research directions. In W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology: Human nature, motivation and change* (pp. 291–308). Washington, DC: American Psychological Association.
Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion and health: An emerging research field. *American Psychologist, 58*, 24–35.
Rambo, L. R. (1993). *Understanding religious conversion*. New Haven, CT: Yale University Press.
Richards, P. S. & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.
Richards, P. S. & Bergin, A. E. (2000). Toward religious and spiritual competency for mental health professionals. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 3–26). Washington, DC: American Psychological Association.
Rodriguez, E. M., & Ouellete, S. C. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members of a gay-positive church. *Journal for the Scientific Study of Religion, 39*, 333–347.
Shafranske, E. P. (1996). Introduction: Foundation for the consideration of religion in the clinical practice of psychology. In E. P. Shafranske, (Ed.), *Religion in the clinical practice of psychology* (pp. 1–17). Washington, DC: American Psychological Association.
Silberman, I. (2005). Religious violence, terrorism, and peace: A meaning-system analysis. In R. F. Paloutizian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 529–549). New York: Guilford Press.
Spilka, B., Hood, R. W., Hunsberger, B., & Gorsuch, R. L. (2003). *The psychology of religion: An empirical approach* (3rd ed.). New York: Guilford.
Stark, R. (2003). *For the glory of God: How monotheism led to reformation, science, witch-hunts, and the end of slavery*. Princeton, NJ: Princeton University Press.
U.S. Department of State (2004). *Annual report on international religious freedom*. Washington, DC: Author.
Van Leeuwen, M. S. (1982). *The sorcerer's apprentice: A Christian looks at the changing face of psychology*. Downer's Grove, IL: InterVarsity Press.

Watson, P. J., Sawyer, P., Morris, R. J., Carpenter, M. I., Jemenez, R. S., Jonas, K. A., & Robinson, D. L. (2003). Reanalysis within a Christian ideological surround: Relationships of intrinsic religious orientation with fundamentalism and right-wing authoritarianism. *Journal of Psychology and Theology, 31*, 315–328.
Weaver, A. J., Kline, A. E., Samford, J. A., Lucas, L. A., Larson, D. B., & Gorsuch, R. L. (1998). Is religion taboo in psychology? A systematic analysis of research on religion in seven major American Psychological Association journals: 1991–1994. *Journal of Psychology and Christianity, 17*, 220–232.
Worthington, E. L., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy, 38,* 473–478.
Yakovlev, A. N. (2004). *A century of violence in Soviet Russia* (A. Austin, Trans.). New Haven, CT: Yale University Press.