Countering a One-Sided Representation of Science: NARTH Provides the "Rest of the Story" for Legal Efforts to Challenge Antisexual Orientation Change Efforts (SOCE) Legislation[11]

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Christopher H. Rosik, PhD, President

National Association for Research and Therapy of Homosexuality

Salt Lake City, UT

[11] In response to state-sponsored legislation to prohibit the provision of sexual orientation change efforts (SOCE) to minors by licensed therapists, NARTH submitted this document to our attorneys at Liberty Counsel. This document was crafted in particular as preparation for possible legal action against New Jersey's anti-SOCE legislation (AB 3371), and it reflects a similar, but less extensive compilation of the information that was entered into the legal record in NARTH's lawsuit against SB 1172 in California. This document was unanimously approved by the NARTH board of directors on July 26, 2013.

Abstract

NARTH compiled science-based information in this document in response to the proposal, passage, and subsequent adjudication of legislation in California (SB 1171) in 2012 and in New Jersey (AB 3371) in 2013 to prohibit the provision of sexual orientation change efforts (SOCE) to minors by licensed therapists. The information in this document is intended for use in various formats to counter the sometimes faulty and often incomplete presentation of science used to defend such anti-SOCE legislation. The information is presented in four sections under the following themes: I. The objectivity of the *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (hereafter referred to as the *Report*) is demonstrably suspect; therefore, the *Report*'s representation of the relevant literature concerning the efficacy of and harm from SOCE is neither complete nor definitive. II. Nonheterosexual identities, attractions, and behaviors are subject to change for many people, particularly youth. III. There is no scientific basis for blaming SOCE for the harmful stigma and discrimination reportedly experienced by persons with a nonheterosexual sexual orientation. IV. Spitzer's reassessment of his *interpretation* of the results of his 2003 study on SOCE does *not* invalidate the results he reported. Licensed mental health professionals (LMHP) who practice some form of SOCE care deeply about the well-being of sexual minority youth and see SOCE as a valid option for professional care, an option that deserves to be protected by state legislatures. LMHPs who do offer SOCE support the right of *all* clients to self-determination.

Statement of Purpose

Five main objectives animate NARTH's submission of this information to the court:

(1) to counterbalance the one-sided presentation of the science related to harm and efficacy of SOCE by proponents of California SB 1172 and New Jersey AB 3371—a presentation that we will demonstrate is a byproduct of an absence of sociopolitical diversity within professional mental health organizations concerning sexual orientation;

(2) to show thereby that claims of the blanket ineffectiveness and intrinsic harmfulness of SOCE are not ultimately grounded in science but rather advocacy, as evidenced strikingly in the differing rigor utilized by these professional organizations to evaluate efficacy and harm;

(3) to underscore from research that minority sexual orientation, particularly among youth, cannot be considered immutable but instead is fluid and subject to change for many, though not all, persons;

(4) to demonstrate that the realities of stigma and discrimination form a highly incomplete understanding of negative health outcomes among nonheterosexual identities, and applying this literature uncritically to SOCE is scientifically and ethically dubious; and

(5) to argue for the propriety of a scientific and research-based response to the questions that remain regarding SOCE instead of a politically inspired legal prohibition that curtails science, of which California SB 1172 and New Jersey AB 3371 are a quintessential expression.

I. The Objectivity of the *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* is Demonstrably Suspect; Therefore the *Report*'s Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE is neither Complete nor Definitive

Bias in Task Force Selection

Although many qualified conservative psychologists were nominated to serve on the APA Task Force (hereafter referred to as the Task Force), all of them were rejected. This fact was noted in a book coedited by a past president of the APA (Yarhouse, 2009). Clinton Anderson—director of the APA's Lesbian, Gay, and Bisexual Concerns Office—offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007).

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 that uniformly endorsed same-sex behavior as morally good. From the outset of the Task Force, then, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within the preexisting worldview of the Task Force. One example of this is the *Report*'s failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the Task Force addressed its work.

Bias Regarding Statements of SOCE Harm and Efficacy

This bias was particularly evident in the Task Force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, Rosik, Williams, & Byrd, 2010). Of

particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm.

With regard to SOCE outcomes, the *Report* dismisses most of the relevant research because of methodological limitations that are outlined in great detail (APA, 2009, pp. 26–34). Studies pertaining to SOCE outcomes that fall short of the Task Force's rigorous standards are deemed unworthy of examination and are dismissed as containing no evidence of value to the questions at hand.

Meanwhile, the *Report* appears to adopt very different evidentiary standards for making statements about harms attributed to SOCE. The standard regarding efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the *Report* uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that "it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

The six studies deemed by the Task Force to be sufficiently methodologically sound to merit the focus of the *Report* targeted samples that would bear little resemblance to those seeking SOCE today; the studies also used long-outdated methods that no current practitioner of SOCE employs. This brings into question the *Report*'s willingness to move beyond scientific agnosticism (in other words, to admit that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The *Report* seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change, and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

There are places in the *Report* that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of, or harms attributable to SOCE. For example, the *Report* states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly, the *Report* observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, 2009, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, 2009, p. 83; cf. p. 67, 120).

These expressions of agnosticism are justified by the Task Force but then are not adhered to in the *Report*'s conclusions. Instead, the *Report* argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the *Report* does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the *Report* goes on to assert confidently that the success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the *Report*, the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14; emphasis added). The harms from SOCE appear to grow greater the further one gets from the original *Report*.

Bias in Favor of Preferred Conclusions

A few examples adequately illustrate that the Task Force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes. The *Report* references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the *Report* is ready to overlook such limitations when the literature addresses preferred conclusions.

First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field; the *Report* and other APA publications affirmed Hooker's work as evidence indicating there are no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an evenhanded methodological evaluation by the Task Force would have not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There were other serious problems, including an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have preexisting psychological problems. Hooker (1993) herself wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology."

Despite these serious methodological problems, which would never be tolerated by the Task Force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). The point here is not to argue for such an association but to underscore that a consistent application of the methodological standards affirmed in the *Report* should have led to the dismissal of the Hooker study as supportive of the no-differences hypothesis.

Bias Regarding Treatment of the Primary Study on Harm

Perhaps the most egregious example of the Task Force's methodological double standard is evidenced in its heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research regarding harm from SOCE. Several

methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, and researchers were given the explicit mandate to find clients who had been harmed and to document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic Therapies: Documenting the Damage" (see Exhibit A).

- More than 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.

- Only 20 participants in this study were women, creating significant skew toward accounts and experiences of gay men.

- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.

- Finally, these subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a nonrepresentative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades

ago. The Task Force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (Shidlo & Schroeder, 2002, p. 250; emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from SOCE conducted by licensed medical and mental health professionals. What we *can* say with confidence is that some SOCE clients report harm and others report benefit—and the literature does not specify how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for legal prohibition.

Bias Regarding the Lack of Context Concerning Harm in Psychotherapy

The APA and other professional bodies that utilize the *Report* are negligent if not fraudulent in giving a technically true warning that SOCE may potentially cause harm but failing to do so within a broader context: This warning certainly applies to all forms of psychological care for any and all problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or may underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of

medical and mental health difficulties *prior* to participating in any SOCE (Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since SOCE commonly involves helping clients become more aware of the stress and distress in their lives in order to manage or alleviate it, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre)existing stress and distress. In other words, they may "feel worse" as a consequence of not having allowed sufficient time for therapy to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high-quality research that might be able to distinguish such causation simply does not exist.

Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior

It should also be mentioned in the discussions of harm and benefit from SOCE that the *Report* makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the United States, but make up only an estimated 2–4% of men in the population (Newcomb & Mustanski, 2011). Despite increasing cultural acceptance, MSM are reporting higher rates of sexual risk behaviors in recent years. Similarly, the prevalence of suicidal ideation and attempts for bisexual and lesbian girls has steadily increased since the mid-1990s (Savin-Williams & Ream, 2007).

Certainly whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet a therapist's efforts to change or otherwise discourage even homosexual behavior among minors, if construed

by the client later as SOCE, could jeopardize the license of the therapist under California SB 1172 and New Jersey AB 3371.

Bias Regarding Research on the Origins of Same-Sex Attractions

Another example of the Task Force's uneven application of methodological standards concerns the *Report*'s conclusion that "studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases; another was a review article that was an interpretation, not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the Task Force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore nongeneralizable sample composed of psychiatric patients. All of these problems were considered to be fatal flaws in the Task Force's appraisal of the SOCE outcome literature for documenting evidence of change.

Given that many of the methodological limitations used by the Task Force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the Task Force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically

flawed that one cannot make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the Task Force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

If such ambiguity exists in the SOCE literature on methodological grounds, then by the Task Force's own criteria, this ambiguity is also present in the referenced etiological research. It appears that the Task Force has been inconsistent in the application of its methodological critique to the broader literature on homosexuality, and it has been willing to offer more definitive conclusions about theories it wishes to dismiss than is warranted by its own standards. In a word, there is again the appearance of substantial bias.

Contrary to the repeated claims of the *Report* that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exists recent, high-quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008; Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the Task Force. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

Bias Regarding Use of the "Gray Literature"

The uneven methodological implementation of standards is again seen in the *Report*'s treatment of the "gray literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale

is offered for this choice. Consequently, a highly scholarly study on SOCE supportive of change for some individuals is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on p. 90 of the *Report*). Yet the Task Force appears to have no compunction in citing the "gray literature" on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

Bias in the APA's Broader Treatment of Sexual Orientation

A sixth example of differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the fifty-nine research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the Task Force applied to the SOCE literature. The Marks study concluded that

> some same-sex parenting researchers seem to have contended for an "exceptionally clear" verdict of "no difference" between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, "the line between science and advocacy appears blurred." (p. 748)

While Marks's analysis does not focus on SOCE, it is relevant in that it underscores that the APA's worldview regarding homosexuality appears to result in public policy

conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the *Report* with the banning of professional SOCE as represented in California SB 1172 and New Jersey AB 3371.

Bias Regarding the Use of the Ryan et al. Study in SB 1172 and AB 3371

A final example of the problem of differential rigor in methodological critique can in fact be found in AB 3371 itself. The bill cites a study by Ryan, Huebner, Diaz, and Sanchez (2009) in the respected journal *Pediatrics*, presumably as its best support for claims that SOCE with minors results in serious harm. It is evident that this study also contains many of the methodological limitations cited by the Task Force to invalidate the SOCE literature, including participants not being blind to the study purposes, apparent biases in the participant recruitment process, and the reliance on self-report measures that had participants recalling experiences from the distant past.

Generalization difficulties are also created by the sample composition of Ryan et al. (2009). The sample is limited to young-adult non-Latino and Latino LGB persons. The APA Task Force (2009) noted that research on SOCE has "limited applicability to non-Whites, youth, or women" (p. 33) and "no investigations are of children and adolescents exclusively, although adolescents are included in a very few samples" (p. 33). This means that even had Ryan and colleagues assessed for SOCE backgrounds among participants, it would be inappropriate to generalize their findings in a manner that would cast aspersions on all SOCE experiences of minors, which again is precisely what AB 3371 is determined to do. In addition, Ryan et al. (2009) acknowledge that "given the cross-sectional nature of this study, we caution against making cause-effect interpretations from these findings" (p. 351).

Presumably, this caution alone should have been enough to prevent the authors of AB 3371 from employing the Ryan et al. study. Even had the study findings been applicable to SOCE consumers, they would not have been able to indicate whether SOCE caused

the negative health outcomes or if youth with negative health markers disproportionately sought SOCE. Based on this analysis, there appear to be no scientific grounds for referencing the Ryan study as justification for a ban on SOCE to minors. The study's findings, while likely reflecting some underlying connection between family rejection and mental health outcomes, are not reliable and have no scientific justification for being generalized to minors who engage in SOCE with licensed therapists. It is troubling that AB 3371 utilizes Ryan et al.'s work when the internal and external validity limitations of the study make such claims profoundly misguided, as underscored by the APA Task Force.

The Task Force concludes that "none of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety" (APA, 2009, p. 2). Taking this statement at face value—which is arguable, as noted above—nevertheless only serves to underscore the enduring validity of comments from Zucker (2003), longtime editor of the *Archives of Sexual Behavior*, who observed:

> From a scientific standpoint, however, the empirical database remains rather primitive and **any decisive claim about benefits or harms really must be taken with a grain of salt and without such data it is difficult to understand how professional societies can issue any clear statement that is not contaminated by rhetorical fervor**. Sexual science should encourage the establishment of a methodologically sound database from which more reasoned and nuanced conclusions might be drawn. (p. 400; emphasis added)

A scientific response as opposed to a response based largely on advocacy would encourage research that will allow for more nuanced conclusions about SOCE, not create a new law that sets the precedent of placing a blanket prohibition on an entire category of psychological care.

II. Nonheterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People, Particularly among Youth

Central to the notion that some individuals can and do report change on a continuum in their sexual orientation is the issue of *immutability*. Were all same-sex attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise, including among minors. However, there is solid data to suggest that same-sex attractions and behaviors are not fixed and are subject to varying degrees of change. As summarized by Ott et al. (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "the importance of viewing sexual orientation as a process which often changes over time" and noted "the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

Nonheterosexuality Is Not a Fixed Trait

The definitive study by Laumann, Michael, and Gagnon (1994), cited by the Task Force, involved several thousand American adults between the ages of eighteen and sixty. This report contains the most careful and extensive database ever obtained on the childhood experiences of matched homosexual and heterosexual populations. One of the major findings of the study that surprised even the authors was that homosexuality as a fixed trait scarcely seemed to exist (Laumann et al., 1994). Sexual identity is not fixed at adolescence but continues to change over the course of life. For example, the authors report:

> This implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42

> percent of the total number of men who report ever having a same-gender experience. (Laumann et al., p. 296)

They also note that their findings comport well with other large-scale studies:

> Overall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys . . . one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

This data seem to suggest that heterosexuality is normative even for those who at one point in the past reported a nonheterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among nonheterosexual individuals" (p. 104).

Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic—in other words, heterosexual. Therefore it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

Whether measured by action, feeling, or identity, Laumann and colleagues' (1994) data concerning the prevalence of homosexuality before and after age eighteen reveal that

its instability over the course of life occurred in one direction toward heterosexuality and reflected significant decline in nonheterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly the picture of sexual orientation stasis in adolescence assumed by California SB 1172 and New Jersey AB 3371. To be fair, we cannot tell from this data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that SOCE could aid some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a nonheterosexual sexual identity is for it to spontaneously disappear unless such is discouraged or interfered with by extraneous factors. Conceivably, non-SOCE therapies that obstruct this process (in other words, those that are "gay-affirmative") could be interfering with normal sexual development.

Diamond's longitudinal studies of women with nonheterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (p. 13; emphasis in original). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12). Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted SOCE as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided parental and informed consent. Finally, echoing the earlier observation by Laumann et al. (1994), Diamond (2005) concluded that "in light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

Change Not Limited to Sexual Behavior

A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of twenty-one and twenty-six, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have to have taken place in the years prior to twenty-one in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

Change Particularly Evident for Youth and Bisexuals

A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy, as it focused on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under sixteen years of age and concluded when participants were nearly twenty-two years old. The authors observed a similar decline in nonheterosexuality over the time of the study, specifying that "all attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, sixteen-year-olds

who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately twenty-five times more likely to change toward heterosexuality at the age of seventeen than those with exclusively opposite-sex attractions are likely to move toward bisexual or exclusively same-sex attractions (Whitehead & Whitehead, 2010). Over the course of the study, 98% of sixteen- to seventeen-year-olds moved from homosexuality or bisexuality toward heterosexuality.

To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that California SB 1172 and New Jersey AB 3371 do not discriminate in their prohibition between SOCE provided for exclusively same-sex-attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the bill's ban distinguish between boys and girls. Savin-Williams and Ream observed that "the instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals" (p. 393). They acknowledged that developmental processes are involved even as they focused mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to SOCE and allow only affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can be only homosexual.

The intent of SB 1172 and AB 3371 for a blanket prohibition on SOCE for all minors with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw: it is unable to address the complex realities of sexual orientation. For example, a study by Herek, Norton, Allen, and Sims (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian

women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in SOCE for some individuals.

Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other studies confirm the particular instability of a bisexual sexual orientation (Savin-Williams et al., 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of SB 1172 and AB 3371. At a minimum, such data suggest that proponents of this legislation would have done better to exclude bisexuality from the scope of this bill. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that SOCE might augment this process for some individuals with unwanted same-sex attractions and behaviors?

Identification of the Mostly Heterosexual Orientation

Further evidence that SB 1172 and AB 3371 ignore distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2 to 3% men and 10 to 16% of women over time, and constituted a sexual orientation larger than all other nonheterosexual identities combined (Savin-Williams et al., 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other nonheterosexual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent physiological evidence in a sample of men (Savin-Williams et al., 2013). This

apparently viable and unique group of nonheterosexuals raises serious questions for the scope of AB 3371—for example, are "mostly heterosexual" minors exempt from the law's ban on SOCE? The fact that SB 1172 and AB 3371 appear to have been outdated even before they were signed into law highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding SOCE at the behest of activists within and outside of professional organizations.

All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth). It also suggests that this change is best conceptualized as occurring on a continuum and not as an all-or-nothing experience. The experience of NARTH clinicians is that while some clients report complete change and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity.

Descriptions of licensed SOCE therapists as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (National Association for Research and Therapy of Homosexuality, 2010). Professional SOCE practitioners recognize that change of sexual orientation typically occurs on a continuum, and this is consistent with how change is understood to occur for most, if not all, other psychological and behavioral conditions addressed in psychotherapy.

Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

Moreover, such fluidity and change makes clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth, and there is no convincing evidence that biology is

decisive for many, if not most, individuals. The American Psychiatric Association has observed that "to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau, Spalding, Conley, and Veniegas (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation .....Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation" (p. 78).

It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> There is *no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation.* Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that *nature and nurture both play complex roles*." (APA, 2008a; emphasis added)

Yet the APA has made minimal effort to publicize the change in its official position on such causation or to correct the accompanying popular misconception—often promoted by the media—that persons with same-sex attractions are simply "born that way." It is difficult not to perceive this as significant professional neglect.

The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large-scale studies of identical twins. These studies indicate that if one twin sibling has a nonheterosexual orientation the other sibling shares this orientation only about 11% of the time (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence on the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses.

Causatively, then, sexual orientation is by no means comparable to a characteristic—such as race or biological sex—that is thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices, such as those that might be facilitated in SOCE. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of SB 1172's and AB 3371's portrayal of same-sex attractions and behaviors as static traits to be embraced only by those minors who might otherwise pursue SOCE.

III. There Is No Scientific Basis for Blaming SOCE for the Harmful Stigma and Discrimination Reportedly Experienced by Persons with a Nonheterosexual Sexual Orientation

Proponents of California SB 1172 and New Jersey AB 3371 frame a significant degree of their arguments concerning harm and SOCE on the negative consequences of stigma and discrimination. While these factors certainly can have deleterious

consequences for those with nonheterosexual sexual orientations, this possibility must be placed within a broader context and balanced by additional considerations.

The Limited Understanding of the Dynamics of Stigma and Discrimination

From an overall perspective, the meta-analytic research (that summarizes results over multiple studies) on the association between perceived discrimination and health outcomes indicates that the strength of this relationship is significant but small (Pascoe & Richman, 2009). Furthermore, research into what influences this association has most typically found no significant role for theoretically linked factors such as social support and identification with one's group. For example, data suggest that the impact of "internalized homophobia" for understanding risk behavior among MSM is now negligible, and "the current utility of this construct for understanding sexual risk taking of MSM is called into question" (Newcomb & Mustanski, 2011, p. 189). By contrast, poly-drug use by these men continued to be a strong predictor of risky sexual behavior. Such findings should be sufficient to indicate that there is a great deal left to be understood about this entire field of study.

Other lines of inquiry suggest that stigma and discrimination alone are far from a complete explanation for greater psychiatric and health risks among nonheterosexual orientations. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. In Holland, men with same-sex attractions and behaviors were found to have a higher risk for suicidal ideation and acute mental and physical health symptoms than heterosexual men, despite that country's highly tolerant attitude toward homosexuality (de Graaf, Sandfort, & ten Have, 2006; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006).

Research in this area is almost entirely reliant on self-reports of *perceived* discrimination, and the relation of this to objective discrimination is not well understood. Recent literature also finds that particular emotion/avoidant-based coping mechanisms

used by people reporting SSA almost entirely account for the effects of this perceived discrimination (Whitehead, 2010). For example, differential rates of health problems resulted from sexual orientation-related differences in coping styles among men, with an emotion-oriented coping style mediating the differences in mental and physical health between heterosexual and homosexual men (Sandfort et al., 2009).

Some Health Outcomes Are Likely Based in Anatomy More Than Stigma

In addition, some health risks, such as HIV transmission among gay men, may be influenced by stigma but are ultimately grounded in biological reality. A recent comprehensive review found an overall 1.4% per-act probably of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer et al., 2012). The authors noted, "The 1.4% per-act probability is roughly 18-times greater than that which has been estimated for vaginal intercourse" (p. 5). Recent CDC statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men is more than forty-four times that of other men (Centers for Disease Control, 2011). Young gay and bisexual men age thirteen to twenty-nine accounted for 27% of all new HIV infections in 2009 and were the only group for whom new HIV infections increased between 2006 and 2009 (Prejean et al., 2011). Sharing such information with prospective SOCE clients is not inherently manipulative but rather, when balanced with other considerations, constitutes an ethically obligated aspect of informed consent.

SOCE Not a Proxy for Stigma or Discrimination

The lessening of stigma associated with "coming out" need not imply an affirmation of a gay, lesbian, or bisexual identity or the enactment of same-sex behavior. SOCE practitioners often encourage the client's acceptance of his or her unwanted same-sex attractions and the disclosure of this reality with safe others as a potential aid in the pursuit of change or, in cases where change does not occur, behavioral management of

sexual identity. This typically occurs when clients desire to live within the boundaries of their conservative religious values and beliefs. While it is often assumed that conservative religious environments are stigmatizing and harmful for sexual minorities by definition, this is by no means a universal finding. One study of black lesbian, gay, and bisexual young adults, 86% of whom were open about their sexual identity, found that "participants who reported lower religious faith scores and lower internalized homonegativity scores reported the lowest resiliency, while those reporting higher religious faith scores and higher internalized homonegativity reported the highest resiliency scores" (Walker & Longmire-Avital, 2012, p. 5).

Referral for SOCE therefore cannot be designated as a proxy for harm-inducing family rejection and stigma, as the proponents of SB 1172 and AB 3371 seem to assume. Only a few studies have directly examined the link between family rejection and health risk among minors (Saewyc, 2011). The derived findings from those studies can be contrary to expected theories, such as the discovery that same-sex-attracted boys who participated in more shared activities with their parents were *more likely* to run away from home and use illegal drugs than those who participated in fewer shared activities (Pearson & Wilkinson, 2013). Even more importantly, no studies have examined family relationships in the context of SOCE participation (APA, 2009). Thus, SB 1172 and AB 3371 would unnecessarily and without scientific warrant eliminate the potential role of conservative religious values for ameliorating the effects of stigma in the context of SOCE. This would prevent clients from one means of prioritizing their religious values above their same-sex attractions when these factors are in conflict. The contention that a desire to modify same-sex attractions and behaviors can only be an expression of self-stigma reflects a serious disregard for and misunderstanding of conservative religious and moral values (Jones et al., 2010).

Encouraging Same-Sex Behavior May Result in Risk-Justifying Attitudes

Finally, new research is raising the possibility that some widely accepted theories germane to the discussion of stigma, discrimination, and health outcomes may in fact have gotten things backward. A longitudinal study of gay and bisexual men by Heubner, Neilands, Rebchook, and Kegeles (2011) found that

> in contrast to the causal predictions made by most theories of health behavior, attitudes and norms did not predict sexual risk behavior over time. Rather, sexual risk behavior at Time 1 was associated with changes in norms and attitudes at Time 2. These findings are more consistent with a small, but growing body of investigations that suggest instead that engaging in health behaviors can also influence attitudes and beliefs about those behaviors. (p. 114)

Thus, safe-sex norms and attitudes did not lead to reduced unprotected anal intercourse; rather, participants' engagement in such HIV-risk behavior appeared to change how they thought and felt about the behavior and enhanced their willingness to engage in it. Such findings raise serious concerns about the impact of SB 1172 and AB 3371: A law that allows only for the affirmation and ultimate enactment of same-sex attractions may in fact increase HIV risk and negative health outcomes for some minors who might otherwise have sought SOCE.

While stigma and discrimination are real concerns, they are not universal explanations for greater psychiatric and health risks among sexual minorities, some of which are likely to be grounded in the biology of certain sexual practices. Moreover, the effects of stigma and discrimination can be addressed significantly within SOCE for many clients, though this is no doubt hard to comprehend for those not sharing the religious

values of SOCE consumers. There is no longitudinal research involving consumers of SOCE that links the known effects of stigma and discrimination to the practice of SOCE. SOCE is simply *ipso facto* presumed to constitute a form of stigma and discrimination. This is in keeping with the persistently unfavorable manner in which SOCE is portrayed by mental health associations. SOCE practitioners and consumers are associated with poor practices as a matter of course (APA, 2009, 2012; Jones et al., 2010). This arguably is a form of stigma and discrimination toward practitioners of SOCE, who have ironically developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to SOCE consumers (NARTH, 2010).

IV. Spitzer's Reassessment of His *Interpretation* of the Results of His 2003 Study on SOCE Does *Not* Invalidate the Results He Reported

Finally, proponents of New Jersey's AB 3371 have understandably pointed out that Robert Spitzer, MD—author of one of the primary studies conducted on SOCE (Spitzer, 2003)—has recently changed his assessment of the study and believes that it does not provide clear evidence of sexual orientation change (Spitzer, 2012). It appears that he may have originally wished to retract the 2003 study, but Kenneth Zucker, PhD—the editor of the journal in which the study was published—denied this request. Zucker has been quoted regarding his exchange with Spitzer as observing:

> You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified—or the journal retracts it if the editor knows of it. As I understand it, he's [Spitzer] just saying ten years later that he wants to retract his interpretation of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to interpretation, and we don't do that. (Dreger, 2012)

What Zucker is essentially saying is that there is nothing in the science of the study that warrants retraction, so all that is left for one to change is his interpretation of the findings, which is what Spitzer appears to have done. Spitzer's change of interpretation hinges on his new belief that reports of change in his research were not credible, an assertion made by others at the time of the study. Instead, he now asserts that participants' accounts of change may have involved "self-deception or outright lying" (Spitzer, 2012).

It is curious that Spitzer's (2012) apology seems to imply that he earlier claimed his researched proved the efficacy of SOCE. As was understood at the time, the design of Spitzer's study ensured his research would not definitively *prove* that SOCE can be effective. Certainly it did not prove that all gays and lesbians can change their sexual orientation or that sexual orientation is simply a choice. The fact that some people inappropriately drew such conclusions appears to be a factor in Spitzer's reassessment. Yet the fundamental interpretive question did and still does boil down to one of plausibility: Given the study limitations, is it *plausible* that some participants in SOCE reported actual change?

Since nothing has changed regarding the scientific merit of the Spitzer study, the interpretive choice one faces regarding the limitations of self-report in this study also remains. Either all of the accounts across all of the measures of change across participant and spousal reports are self-deceptions and/or deliberate fabrications, or they suggest it is possible that some individuals actually do experience change in the dimensions of sexual orientation. Good people can disagree about which of these interpretive conclusions they favor, but assuredly it is not unscientific or unreasonable to continue to believe the study supports the plausibility of change.

In fact, the reasonableness of this position has been bolstered recently by the willingness of some of the participants in Spitzer's research to speak up in defense of their experience of change (Armelli, Moose, Paulk, & Phelan, 2013). They expressed clear disappointment in Spitzer's new claims:

> Once thankful to Spitzer for articulating our experience and those of others, we are now blindsided by his "reassessment," without even conducting empirical longitudinal follow-up. We know of other past participants who also feel disappointed that they have been summarily dismissed. Many are afraid to speak up due to the current political climate and potential costs to their careers and families should they do so. (p. 1336)

It seems clear, then, that 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 sexual orientation.

Concluding Statements

There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and see SOCE as a valid option for psychological care, while simultaneously affirming the client's right to pursue gay-affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against SOCE, the information in the present document should be sufficient to question the scientific (not to mention Constitutional) merits of California SB 1172 and New Jersey AB 3371.

As we noted at the outset:

(1) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of SB 1172 and AB 3371 portray them to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists regarding sexual orientation research.

(2) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery regarding SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(3) An impressive body of scientific data indicates that nonheterosexual sexual orientations should not be viewed as always immutable but are often, though not always, subject to change, especially among youth.

(4) The role of stigma and discrimination on negative health outcomes among nonheterosexual identities is real but provides only a small and partial understanding of these concerns. Most importantly, applying this literature uncritically to SOCE is scientifically and ethically dubious.

(5) The proper course of action for politicians and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not to place a ban on its professional practice that supersedes existing regulatory oversight and may create unintended consequences for licensed therapists.

As this brief has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner, but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE-sympathetic psychologists from the APA Task Force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm.

As the Task Force noted, the prevalence of success and harm from SOCE cannot be determined at present. Anecdotal accounts of harm, which are a focal point of attention by supporters of SB 1172 and AB 3371, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal level. While such "hearsay" evidence is "not nothing," it is negligent if not fraudulent that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better-documented claims that experiences of SOCE were "beneficial" and were not "harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from SOCE (see http://www.voices-of-change.org/). Furthermore, accounts of harm cannot tell us if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates that 5 to 10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

The normative occurrence of spontaneous change in sexual orientation among youth, the nontrivial degree of choice reported by some in the development of sexual orientation, and the questionable blanket application of the literature on stigma and discrimination to SOCE further bring into question the appropriateness of SB 1172 and AB 3371. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, high-quality research is needed to confirm this suspicion. However, it should be mentioned in this regard that SB 1172 and AB 3371 would make further research on SOCE with minors impossible in California and New Jersey, respectively, despite the APA Task Force's clear mandate that such research be conducted (APA, 2009).

Any genuine harm that results from SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including

informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. It is questionable and unlikely that the tangible, prosecutable harms from SOCE are as widespread as SB 1172 and AB 3371 sponsors claim. If such harms did exist, why have we heretofore not seen SOCE practitioners losing their licenses and mental health association memberships in droves? Both SB 1172 and AB 3371 are a legislative overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and nonheterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by SB 1172 and AB 3371, a distinction these laws do not make.

Proponents of SB 1172 and AB 3371 reason that because homosexuality is no longer considered to be a disorder, providing professional SOCE to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs—such as beliefs that divorce or abortion are wrong—and may experience significant emotional distress in addressing these issues. In this context, the selective attention that SB 1172 and AB 3371 give to SOCE again hints at political advocacy rather than science as a primary inspiration for this law.

The religiously conservative faith community will not be well served if SOCE among minors is judged *never* to be an appropriate modality for psychological care, especially when the affirmative interventions include the correction of the client's "false assumptions." Should the court agree with this line of argument, then the court

is unconstitutionally taking a stand on the validity of certain forms of religious belief. By implying that there is always a better method than any form of SOCE, backers of SB 1172 and AB 3371 presume to know what form of psychological care for unwanted same-sex attractions and behaviors is best for the religiously motivated minor clients and their parents. Neither the courts nor the APA should be substituting their judgment for that of a seventeen-year-old who is calculating a cost-benefit analysis in deciding whether to undergo SOCE despite the risks. The APA is quite clear that it supports the competence of a seventeen-year-old girl to give consent to an abortion. Why does the seventeen-year-old lose competence when it comes to SOCE? Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b), and AB 3371 explicitly protects this option. Is it reasonable that seventeen-year-olds who believe themselves to be the wrong biological sex be allowed to surgically alter genitalia while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of recent high-quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne et al., 2011).

The Task Force *Report* (APA, 2009) and the mental health associations that subsequently relied on it for their resolutions on SOCE provide one viewpoint into research and reasoning that likely has some merit but must be considered incomplete and therefore not definitive enough to justify a complete ban on SOCE with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Redding, 2001) that has an inhibitory influence on the production of scholarship in controversial areas such as SOCE that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is

a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board). (p. 90)

Such diversity is precisely what is currently lacking in professional mental health organizations and their associated scientific communities when it comes to the study of contested social issues related to sexual orientation, including SOCE (Wright & Cummings, 2005). If this were not true, it would be hard to understand how the American Psychological Association's leadership body—the Council of Representatives—could vote 157-0 to support same-sex marriage, a result that undoubtedly represents a "statistically impossible lack of diversity" (Jayson, 2011; Tierney, 2011).

To repeat a final time, a truly scientific response to the concerns of the sponsors of California SB 1172 and New Jersey AB 3371 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. SOCE practitioners would assuredly embrace such an opportunity (Jones et al., 2010). Unfortunately, the approach taken by SB 1177 and AB 3371 sponsors represented only one political and legislative perspective on how to best address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. That approach is therefore a scientifically premature—and unjust—curtailment of the rights of current and potential SOCE consumers, their parents, and their therapists and should not be allowed to stand.

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