Fact-Checking California Senate Bill 1172[1]— Serious Inaccuracies and Distortions Abound: Are Politicians Willing to Listen?

May 18, 2012

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The same week California governor Jerry Brown announced that the state was now $16 billion over budget, with the implication that more social-welfare cutbacks affecting thousands of children would be necessary, SB 1172 was passed by the California Senate Judiciary Committee. It will now enter deliberation by the full California Senate with a stated purposed to protect an unknown number of minors and others from the "dangers" of sexual orientation change efforts (SOCE).

Even the *L.A. Times*, not known to be a voice of conservatism, has come out against this legislation, saying it constitutes unnecessary government intrusion into what should be mental health association policy matters. (On matters of science, however, the *Times* naively accepted the picture spun by the sponsors of SB 1172; see htttp://articles.latimes.com/2012/may/11/opinion/la-ed-0511-therapy-2012051).

But will this legislation really do much to protect minors and adults who might otherwise avail themselves of SOCE? When we examine some of the contentions SB 1172 touts as "facts," greater clarity can be obtained regarding the partisan nature of this bill.

SB 1172: States that SOCE practitioners use aversive treatments such as electric shock or nausea-inducing drugs.

Fact: Aversive treatments were common for a wide variety of psychological conditions in the 1960s and 1970s, including sexual orientation (see http://narth.com/2011/05/facts-and-myths-on-early-aversion-techniques-in-the-treatment-of-unwanted-homosexual-attractions/). However, aversive treatments were eventually determined to be ineffective in addressing sexual orientation and have not been utilized for decades. In fact, in a quick analysis of the psychological and medical databases, I could find no published new research on aversive treatments and homosexuality after 1981. Similarly, the APA's (2009) *Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation* did not identify any such studies after 1981. Even the bill's authors had to

rely on a 1994 report from the American Medical Association, a nearly twenty-year-old document.

The linking of SOCE practitioners with aversive and shock treatments is a favorite smear tactic of SOCE opponents, but it has not had any basis in fact for more than thirty years. Moreover, NARTH is on record as *not* recommending these practices due to ethical and efficacy concerns (NARTH, 2010). The fact that this inaccuracy is highlighted so prominently in SB 1172 certainly lends credence to the suspicion that the primary aim of the bill's sponsors is to demonize SOCE and the clinicians who engage in this practice.

SB 1172: Claims that SOCE can be harmful or carry some risk of harm and that this is something SOCE practitioners deny.

Fact: SOCE, as is the case with all forms of psychological care, carries some risk of harm. No professional therapist engaged in SOCE would deny this. The question is whether SOCE carries an exceptionally greater risk than all other forms of psychological intervention—and the answer is that no studies exist that can truly speak to this issue. The studies cited by the APA task force (2009) concerning harm are unable to be generalized beyond their specific samples, and the task force report concluded, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (p. 42). For the sponsors of SB 1172 to use this literature as a means of casting aspersions on all SOCE is an act of scientific dishonesty.

The most popularly cited study regarding harm from SOCE (Shidlo & Schroeder, 2002) *specifically warns* readers about generalizing from their research, which did not distinguish licensed professionals and religiously based providers of SOCE in their reports of harm. Furthermore, the authors of the study advertised for respondents with this notice: "Help Us Document the Harm." To be able to know the exact prevalence

of harm in SOCE and the significance of this prevalence rate, we would need to see prospective, longitudinal studies using representative samples, *not* personal anecdotes or samples that were advertised as being sought to "help" the researchers achieve a desired outcome. Such studies would need to track harm in other forms of psychological intervention (such as marital therapy) for interpretive comparison. The fact that an intervention might be harmful in the absence of any scientific data that speak to the prevalence and significance of this harm is not a sufficient justification for banning or marginalizing an intervention. An ideologically based political activism rather than an objective scientific outlook appears to again be lurking in the background of SB 1172.

SB 1172: Claims that the bill will protect minors from the potential, harmful effects associated with SOCE, including severe mental or emotional problems such as suicide.

Fact: Notwithstanding the considerations regarding claims of harm noted above, there is reason to believe that *this bill* will likely *increase* harm to minors through its unintended consequences.

Here's how I come to this very plausible conclusion. It would appear quite likely that the majority of parents who bring their children to therapists for SOCE are conservatively religious. SB 1172 sponsors assume that if SOCE is prohibited among licensed mental health professionals, these parents would then bring their children to clinicians who would provide only that care aimed at encouraging their children to embrace their GLB identity and behavior.

I think the more likely scenario is that these parents, many of whom are already suspicious of the mental health professions, will simply pursue SOCE for their children from unlicensed, unregulated, and unaccountable religious counselors who do not fall under the jurisdiction of this bill. The vast majority of anecdotal accounts of harm to minors from SOCE seem attributable to these types of counselors and to religiously

oriented programs. Parents who receive professional care by SOCE clinicians whom they sense are understanding of and sympathetic to their worldview will be receptive to their guidance, especially when their child is not interested in SOCE. It is highly unlikely that the average unlicensed conservatively religious counselor will be as sensitive to the contextual and motivational considerations licensed therapists must assess when determining if change-oriented intervention is appropriate for a minor client. This is a prescription for an increased risk of harm. It would indeed be a tragic but foreseeable irony if the sponsor's zeal to ban SOCE for minors via SB 1172 ends up actually increasing the harm these youth experience.

SB 1172 makes it clear that SOCE includes "psychotherapy aimed at altering the sexual or romantic desires, attractions, or *conduct* of a person toward people of the same sex so that the desire, attraction, or *conduct* is eliminated or *reduced* or might instead be directed toward people of a different sex" (Article 15. 865 [d]; emphases added). This language seems to imply that psychotherapeutic intervention to reduce same-sex behaviors among minors is to be prohibited. It is worth asking whether such broad language will have a chilling effect on even non-SOCE therapists who are asked to help minors reduce or manage their addictive or compulsive same-sex behaviors. It seems quite conceivable that a minor at some later point could feel retrospectively slighted by this treatment and therefore be enticed by SB 1172 to file legal action against the therapist to the tune of up to $5,000.

So again, another unintended consequence of this bill could be to reduce the pool of non-SOCE therapists willing to wade into the incredibly murky clinical waters that SB 1172 would create, thus increasing harm by reducing the availability of any psychological services to LGB youth in California.

One last observation that can provide further perspective: One wonders what the sponsors of SB 1172 would say about a widespread intervention for minors that carries the following warning: *"[This intervention] increased the risk of suicidal thinking and*

behavior (suicidality) in short-term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders." This is, in fact, the warning for the antidepressant Prozac. You can check out the potential side effects for other medications at www.pdf.net. It seems to me that if we are going to begin to ban certain types of psychological interventions on the basis of real (as opposed to uncertain) harms to minors, the sponsors of SB 1172 should be spending a lot more time focusing on the millions of youth (including GLB youth) currently being prescribed these powerful psychoactive medications (I say this as a therapist who thinks medications can have a place in treatment but are currently being overprescribed).

SB 1172: Defines informed consent for adult clients as having to include four statements from mental health organizations about SOCE.

Fact: The statements used in SB 1172 are actual pronouncements, but the lack of context is clearly meant to depict SOCE in deceptively unflattering terms. The degree to which these four statements have been cherry-picked to provide an unduly negative picture of SOCE can be seen in their publication dates. Three of the four were published between 1993 and 1997, which makes me wonder if these associations have in nearly twenty years said nothing that the sponsors of SB 1172 found sufficient for their purposes. Only the APA's (2009) task force report was recent in origin. Unfortunately, the task force consisted only of psychologists who were against SOCE from the start and excluded several excellent scholars sympathetic to SOCE (Jones, Rosik, Williams, & Byrd, 2010).

This fact raises the curtain on the sociopolitical culture within the major professional mental health associations. While they do good work on many fronts, when it comes to social issues being debated in the culture, the APA and other associations are reliably left of center in their outlook. One example suffices: In 2011, the APA council of representatives voted **157-0** to support gay marriage. This is not a typographical

error. *Not a single vote* in favor of the keeping the male-female definition as the social ideal. This is a statistically impossible lack of diversity. Whatever one believes about this issue, it stretches incredulity to contend that such a vote does not reflect a mix of political activism and political correctness. In a similar fashion, I believe that many of the pronouncements concerning SOCE cited in SB 1172 represent what occurs in professional mental health organizations when science is allowed to stagnate in the absence of support for viewpoint diversity.

Former APA president Dr. Nicholas Cummings observed that while unsuccessful attempts have been made in the APA to ban SOCE, the APA refused to take a stand on "rebirthing therapy," which resulted in the suffocation death of one child when the birth process was simulated with tight blankets (Cummings, 2008). Cummings then concluded, "If the APA rushes to judgment in the matter of sexual reorientation therapy while remaining derelict in its silence toward proven harmful techniques, therapists will be intimidated and patients will lose their right to choose their own treatment objectives. The APA, not the consumer, will become the de facto determiner of therapeutic goals" (p. 208). This sentiment is equally valid for SB 1172—only in this case California politicians, not the California consumer, will dictate which goals for psychological care are acceptable.

SB 1172: Says that SOCE assumes that homosexual orientation is both pathological and freely chosen.

Fact: SB 1172 provides no documentation to support this claim. In fact, NARTH represents many professional SOCE providers and is on the record as taking the position that same-sex attractions are usually *not* something people choose in some volitional manner (NARTH, 2010). Though historically many SOCE providers (not to mention most mental health professionals in general) viewed homosexuality as psychopathological, this

is typically not the case today. NARTH's position is rather that same-sex attractions and behavior may reflect a developmental adaptation to certain biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition. And while this adaptation may not constitute psychopathology per se, it does appear to place these individuals at greater risk for mental illness and physical disease, not all of which is likely to be attributable to social stigmatization.

In conclusion, this quick tour through some of the factual claims made by the sponsors of SB 1172 makes it clear that this legislation is playing fast and loose with its assertions about SOCE. It would be a travesty of immense proportions if the California legislature allows these falsehoods and inaccuracies to be enshrined into California law. It would also constitute a corruption of the political process by activists who would certainly invite a legal challenge.

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