Ideas for counter brief to State's arguments for SB1172

Does the sexual orientation change therapy that SB1172 seeks to ban, include reparative therapy that merely aims to repair the guilt and shame from troubled parental relationships, trauma from sexual abuse or child/adolescent school age peer related abuse could be outlawed for no good reason? Same sex attraction and homosexuality can decrease with merely reparative therapy that seeks to decrease the shame and guilt that have led to the disordered attraction in the first place.

Homosexuality is not a normal expression of human sexuality

The scientific and professional consensus that homosexuality is a normal expression of human sexuality and is not a disease, condition or disorder in need of a 'cure' is a politically motivated conclusion. It is not based on philosophical, ethical, scientific or consensus opinion.

The decisions by the American Psychiatric Association (APsyA) in 1972/3 and American Psychological Association (APA) in1974 to declare that "homosexuality" itself was no longer a diagnosable and treatable disorder were political – not scientific. In 2003, members of the APsyA decided to declassify homosexuality itself as a psychiatric disorder through a non-representative vote of its membership, in the presence of its historical and reasonably successful treatment for fifty years and in the absence of any new or compelling research that it should not be. In effect, this was a political decision. Various authors - including those who favored and those who opposed this decision identified this so – then and now.

Assertions by the APA in its 2009 Task Force Report that homosexuality normal and natural are substantiated simply by citing these political decisions and two LGB affirmative therapists. No research which either preceded or followed any of these political or personal opinions substantiates the claims of normality.

Noted anthropologists, historians and sociologists JD Unwin, Arnold Toynbee, Carl Wilson, Brian Fitzpatrick, Carle Zimmerman and Pitirim Sorokin, all note similar conclusions in their studies of civilizations throughout human history: sexual monogamy, traditional marriage and abstinence are the foundations of civilization. Deviations from this lead to society's decline and downfall.

SOCE is not harmful

SB1172 claims that SOCE is harmful or dangerous but both APA, APsyA and all of the various mental health organizations are severely negligent when they warn potential clients about the *potential for harm* in receiving SOCE. In reality, a potential which the APA fails to acknowledge exists for any and all forms of "psychological help" for any and all forms of "presenting problems or concerns". No approach to mental – let alone medical - healthcare is without some risk. For APA, et al., to give a technically true warning that SOCE may potentially cause harm – and not do so in the context that every other approach to psychological or

professional care also does, is not just negligent, but fraudulent. These are better documented in Section 2 of *Journal of Human Sexuality (JHS),* Volume 1, (http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1), and Guideline 6 or NARTH Practice Guidelines (http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines). The APA is in violation of the first point in its *Ethical Practices and Code of Conduct* (http://www.apa.org/ethics/code/principles.pdf), namely APA has let SB 1172 declare uncorrected that the APA "task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people." **The APA actually concluded, but has not corrected SB 1172 promoters that: "[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**" (*Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (*http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf*), p. 83; cf. p. 67, 120). SB1172 has not even cited their main source correctly. That appears to be one of the biggest foundations of their entire case.

The APA arbitrarily dismisses 50 years of clinical and scientific reports, including therapist and client claims of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex , as methodologically unacceptable, but admits as acceptable more recent reports – i.e., retrospective claims of "harm" as acceptable. APA also claims that research studies which support its own ideological biases (i.e,. SOCE are harmful, "gay-affirmative therapies" are helpful) do not meet the standards used to reject studies which do not support the APA ideological bias. See JHS 4 articles: Christopher Rosik PhD, *Did the APA Task Force on Sexual Orientation Change Efforts Apply its Research Standards Consistently?,* and James E. Phelan PhD, Arthur Goldberg JD, and Christopher Doyle PhD, *A Critical Evaluation of the Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, Resolutions, and Press Release.* See also, ***A Formal Response to the Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, National Association for Research and Therapy of Homosexuality (NARTH)** http://narth.com/2011/01/a-formal-response-to-the-report-of-the-american-psychological-association-task-force/

Sexual orientation can change

Encapsulated in the SB1172 argumentation against SOCE is the notion that sexual orientation cannot change. The APA Task Force Report attempted to identify an objective phenomenon (orientation) vs. a subjective phenomenon (identity). "Sexual orientation" is defined as an unchangeable characteristic, while "sexual identity" is changeable. Yet, the Report also admits as a "psychological fact" that for some people, *sexual orientation identity* – but not orientation itself – is "fluid." This is pseudo-science (at best, conjecture, with no objective way of clarifying someone's orientation — i.e., real self) from their self-reported identity (i.e., "individual or group membership or affiliation, self labeling," Clients do report satisfaction with efforts to change their "sexual orientation." How one defines "sexual orientation" affects how

one measures and attempts to change this phenomenon, and whether or not one has, in fact, been helped.

The APA Task Force Report defines "sexual orientation" as *"an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics" and states that "orientation is tied to* ***physiological drives and biological systems that are beyond conscious choice*** *and involve profound emotional feelings"* (pg. 30; cf. its definition of "sexual orientation identity"). While it can be acknowledged that persons typically don't choose to develop such physiological drives, arousals, desires, etc., the latest neuro-bio-psycho-social research reveals the "plasticity" and "learnability" of "physiological drives, arousals, desires, etc.," and behavioral habits as well as ways of gratifying or expressing them. Dr. Neil Whitehead writes extensively about this in *My Genes Made Me Do It ! A scientific look at Sexual Orientation (*http://www.mygenes.co.nz/), which includes an analysis of the classic Lauman, et al., study. He writes in summary: "Neutral academic surveys show there is substantial change. About half of the homosexual/bisexual population (in a non-therapeutic environment) moves towards heterosexuality over a lifetime. About 3% of the present heterosexual population once firmly believed themselves to be homosexual or bisexual. Sexual orientation is not set in concrete." (http://www.mygenes.co.nz/myths.htm) So, since youths - and adults - do change a lot, mostly without therapeutic, by what right does the state prevent people from enlisting professional help? (Family Research Council pamphlet http://downloads.frc.org/EF/EF10F01.pdf)

Clients have the right to determine their own direction of treatment.

As the *APA Task Force Report* says, Licensed Mental Health Providers (LMHP) "should strive to maximize autonomous decision making and selfdetermination and avoid coercive and involuntary treatments**"** (p. 76). Professionals who are members of NARTH and non-members who practice ethically believe along with APA "that LMHP are more likely to maximize their clients' self determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation" (p. 69), and that "clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns" (p. 63). Religious beliefs in regards to homosexuality must be respected (cf. p. 5, 19-20, 51, 53, 56, 59, 64, 69, 70, 77-78, 82, 120), as well as the convictions of those who decide (apart from religious reasons) that their sexuality does not reflect their true self (cf. p. 18, 56, 68-69). See NARTH's *Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior* (http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines) for a clear deliniation of what NARTH deems is ethical practice to persons with unwanted same sex attraction.