

30 September 2014

IFTC Intervention at OSCE/ODIHR 2014 Review Conference Warsaw

To: The Organization for Security and Co-operation in Europe (OSCE) Office of Democratic Institutions and Human Rights (ODIHR) Human Dimension Implementation Meeting (HDIM)

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Date: Tuesday, 30 September 2014: *Working Session 12*

Regarding: *Tolerance and Non-discrimination II*

Unjust Legal Sanctions Threaten the Rights of Children and Adults to Receive—and Competent Medical and Mental-Health Professionals to Provide—Freely Sought Professional Care to Manage or Change Unwanted Same-Sex Attraction (SSA)

This intervention is being given on behalf of the International Federation for Therapeutic Choice (IFTC, <http://www.narth.com/#!iftc/c8me>). The IFTC supports the rights of sexual minorities who have unwanted attractions, orientation, behavioral tendencies, behavior, and/or identity (i.e., self-identification) to receive competent professional guidance and therapeutic care. The IFTC also supports the rights of medical and mental-health professionals to offer that care. (Copies of related IFTC interventions at the 2011, 2012, and 2013 HDIM may be retrieved from <http://www.narth.com/#!iftc-reports/c1qbu><http://www.narth.com/#!iftc/c8me>.)

Central Recommendation to Participating States of the OSCE:

To draft legislation to safeguard the freedom of:

- 1. Minor and adult persons to receive freely sought professional care in order to eliminate, diminish, or manage unwanted sexual minority feelings, behavior, and/or identity.**
- 2. Medical and mental-health practitioners, educators, and researchers to offer professional education, guidance, and therapy to minors (with the support of their parents) and adults who freely choose such care in order to eliminate, diminish, and/or manage any unwanted sexual minority feelings, behavior, and/or identity.**

Unwanted same-sex attraction (SSA) is a fairly common reason that young people request professional help or seek support groups. Change in same-sex feelings, thoughts, behavior and self-identification is best understood as occurring on a continuum. Scientific research has clearly demonstrated that, with competent psychotherapy provided by qualified professional therapists, a considerable proportion of people with SSA can have unwanted attraction reduced and related behaviors changed. A smaller percentage are able to develop their heterosexual potential as well, some radically so.

Unfortunately, some small but highly vocal groups have objected to professional therapists performing such work, and have sought in a number of countries to restrict or prohibit qualified professionals from helping persons who desire such help. But the reasons for advocating such an invasion of the right of an individual to seek such professional help are most often based upon claims and allegations that are clinically and scientifically inaccurate.

Two basic scientific claims made by advocates seeking to stop people with unwanted same-sex attraction from obtaining professional help are: 'That homosexuality is an innate, immutable, and positive alternative of human

sexual expression.” And, “That professional care to help persons manage and change same-sex attractions and behavior is generally or invariably ineffective and harmful.” Each of those propositions can be demonstrated to be scientifically incorrect and untrue.

Clinical and scientific research has shown that same-sex attraction (SSA) is *not innate* and that SSA is “fluid” or changeable, *not immutable*. Research also documents that typical homosexual behavior and lifestyle involve extreme risks for medical harm and psychological difficulties.

Finally, a century of professional and scientific reports document that professional care to help persons to manage and change unwanted same-sex attractions, thoughts, behavior or “identity” (self-identification) does not help many persons who pursue it. Such professional assistance has *not* been shown to be generally, invariably or unacceptably harmful to those who receive it.

Research also shows that managing or changing unwanted SSA and behavior is a reasonable goal because of the significantly increased health risks associated with the behavior and lifestyle. Attempting to change SSA is also often motivated by a desire to live congruently with one’s personal beliefs and values. Societal discrimination has *not* been shown to be a significant cause of the increased risk for concurrent medical, psychological and behavioral difficulties experienced by persons with SSA. *All* sexual minorities whose experience of life is not congruent – including but not only those with SSA – deserve the right to receive professional education, guidance, counseling, therapy and medical care in service of their personal needs and life goals. *All* medical and mental health professionals deserve the right to offer such care.

What follows are specific propositions in support of the preceding introduction. The references cited below were chosen because of their 1) relevance; 2) ease of access; and 3) containing citations of many more clinical and scientific studies in support of each proposition. The statements and references are offered as an introduction for nonprofessionals to a fair reading and responsible summarizing of the clinical and scientific literature on this topic.

1. Clinical and scientific research shows that same-sex attraction (SSA) is not innate.

No credible studies support the hypothesis that persons with SSA, i.e. those who have a so-called “gay, lesbian, or bisexual orientation,” are simply *born that way*. The most recent scientific evidence clearly shows that, in spite of many premature claims, no biological factor has been found to cause *any* “sexual orientation,” and research findings have made heredity or other biological causes increasingly improbable.

- *“Many scientists share the view that: sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors.” These factors include “life experiences during early childhood.”*

American Psychological Association (APA; 1998) Answers to Your Questions about Sexual Orientation and Homosexuality.

- *“There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian 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 (2008). Answers to your questions: For a better understanding of sexual orientation and homosexuality (<http://www.apa.org/topics/sexuality/orientation.aspx>):

- “From six studies (2000-2011), if an identical twin has same-sex attraction the chances that the co-twin has it too are only about 11% for men and 14% for women. This means that factors the twins have in common, such as genes and upbringing, are mostly not responsible – individual and idiosyncratic responses to random events and to common factors predominate.”

Whitehead (2012). *Common Misconceptions About Homosexuality: People with SSA are not born that way! Our genes do not make us do it!* (<http://www.mygenes.co.nz/myths.pdf>)

2. Same-sex attractions and behavior are “fluid” or changeable, not immutable.

- Scientific research documents that many persons are able to manage and change SSA, *without* professional assistance. According to the American Psychological Association:

“Recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid” (p. 14). This report mentions in particular the “experiences of fluidity and variation in sexuality and relationships” among *women* (p. 63) and that the “sexual orientation identities” of *adolescents* “may not be exclusive or dichotomous,” i.e. may be “fluid or flexible” (p. 76).

APA (2009). *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>)

- Researcher Lisa Diamond has documented that the “sexual orientation” of *both* males and females is “fluid,” *without* professional assistance

Diamond, Lisa. (2008). *Sexual fluidity: Understanding women’s love and desire*. Cambridge, MA: Harvard University Press.

Diamond, Lisa (2013). *Just how different are female and male sexual orientation?* Cornell University, College of Human Ecology. (Posted on 5 December 2013). Retrieve from <http://www.cornell.edu/video/lisa-diamond-on-sexual-fluidity-of-men-and-women>

- “(T)he scientific literature shows that sexual orientation is not fixed but fluid. People move around on the homosexual-heterosexual continuum to a surprising degree in both directions, but a far greater proportion of homosexuals become heterosexual than heterosexuals become homosexual. Some of the change is therapeutically assisted, but in most cases it appears to be circumstantial. Life itself can bring along the factors that make the difference.” (Pg. 224)

Neil Whitehead & Briar Whitehead (2013). *My Genes Made Me Do It!: Homosexuality and the scientific evidence* (Third Edition). (<http://www.mygenes.co.nz/download.htm>)

- “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” (Misconception 10).

Whitehead, N.E. (2012): *Common Misconceptions* (<http://www.mygenes.co.nz/myths.pdf>)

3. Scientific evidence shows that there is a significant amount of change in same-sex attraction for both males and females, particularly during adolescence.

“The idea that adolescent same-sex attraction will always become adult same sex attraction is quite incorrect. Data from the large USA ADD-Health survey (Savin-Williams and Ream, 2007) confirm that adolescent homosexuality/bisexuality both in attraction and behaviour undergoes extraordinary change from year to year. Much of this could be experimentation. The changes are overwhelmingly in the direction of heterosexuality, which even at age 16-17 is at least 25 times as stable as bisexuality or homosexuality, whether for men and women.”

Whitehead, N.E. (2009): Adolescent Sexual Orientation: Surprising amounts of change (<http://www.mygenes.co.nz/Change.htm>):

- *“In the West today, 98% of today’s teens who believe they are homosexual at 16 will believe they are heterosexual one year later. It is irresponsible to offer gay affirmative counselling to teens on the grounds that the homosexual orientation is intrinsic and fixed” (Misconception 11).*

Whitehead, N.E. (2012): Common Misconceptions (<http://www.mygenes.co.nz/myths.pdf>)

4. Professionally assisted change in same-sex feelings, thoughts, behavior and “identity” – i.e. self-identification – occurs on a continuum. A century of clinical and scientific studies document that professional assistance has been effective for many persons with unwanted SSA.

- *“Change in sexual orientation is better conceptualized as occurring on a continuum; not as an all-or-nothing experience. Some clients report “complete,” others “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 in their behavior and sexual orientation identity.”*

NARTH Institute Statement on Sexual Orientation Change (2012)
<http://www.narth.com/#!about1/c1wab>

- *“What Research Shows (NARTH, 2009) reviews 125 years of clinical and scientific reports which document that professionally-assisted and other attempts at volitional change from homosexuality toward heterosexuality has been successful for many and that such change continues to be possible for those who are motivated to try. Clinicians and researchers have reported positive outcomes after using or investigating a variety of ... paradigms and approaches ...to treat homosexuality, including psychoanalysis, other psychodynamic approaches, hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, pharmacology, and others. In many cases, combinations of therapies have been used. There also have also been reports of spontaneous change, i.e. of persons experiencing various degrees of “sexual reorientation” without professional or pastoral guidance.” (p. 2, emphasis added)*

National Association for Research and Therapy of Homosexuality (NARTH) (2009). What research shows: NARTH’s response to the APA claims on homosexuality. Summary of Journal of

Human Sexuality, 1. Retrieve from: <http://www.scribd.com/doc/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1>

James E. Phelan, Neil Whitehead & Philip M. Sutton (2009). *What Research Shows: NARTH's Response to the APA Claims on Homosexuality. A Report of the Scientific Advisory Committee of the National Association for Research and Therapy of Homosexuality. Journal of Human Sexuality*, 1, 1-128. Retrieve from <http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1>

- Stories of how persons with unwanted same-sex attractions and behavior were able to use professional therapeutic and other services to experience intended changes in those attractions and behaviors are available for public review. Please note: Some of these persons credit pastoral ministry, group support, and other resources as also important to their process of change.

Voices of Change: Men and Women Who Have Experienced Authentic Change in Sexual Orientation Through Therapy that Works! <http://voices-of-change.org/>

Alliance Partners Share Their Personal Stories of Growth <http://www.therapeuticchoice.com/#!/voices-of-growth/c1bdg>

5. Seeking professional assistance to manage or change unwanted same-sex attractions, behavior or identification has *not* been shown to be generally, invariably or unacceptably harmful to those who try.

- Legislative and professional activism which attempts to prevent professionals from providing and people from receiving professional assistance for unwanted SSA commonly use the single, 2002 study by Shidlo and Schroeder as justification. In their report, the authors themselves declare:

“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” (p. 250, emphasis in the original).

Shidlo, A., & Schroeder, M. (2002). *Changing sexual orientation: A consumer's report. Professional Psychology: Research and Practice*, 33(3), 249–259. Retrieved from http://antigayfactcheck.files.wordpress.com/2012/10/changing_so_consumers_report_ashidlo_pprp_2002_249-259.pdf.

(Please note: “Conversion therapy” is one of several generic names – “reorientation” and “reparative therapy” are others – commonly given by critics to the practice of professional and other assistance for unwanted SSA. Unfortunately, those who use these terms include as “therapists” persons like pastors and other non-professionals who have not been trained to provide “therapy.”)

- Ironically, the Shidlo and Schroeder (2002) study has been wrongly cited as proof that professional care for unwanted SSA is unacceptably harmful to clients and as a sufficient basis for legislation to ban such professional care.

IFTC (2013). *What Research Does and Does Not Say about the Possibility of Experiencing “Harm” by Persons Who Receive Therapeutic Support for Unwanted Same-Sex Attractions or “Sexual Orientation Change Efforts (SOCE)”*. <http://www.scribd.com/doc/206713194/What-Research-Does-and-Does-Not-Say-about-the-Possibility-of-Experiencing-Harm-by-Persons-Who-Receive-Therapeutic-Support-for-Unwanted-Same-Se>

- The American Psychological Association admits that there is insufficient evidence to claim that professional assistance offered to persons with unwanted SSA is either ineffective or unsafe.

“None of the recent research...meets methodological standards that permit conclusions regarding efficacy or safety” (p. 2.) “Recent SOCE (sexual orientation change efforts) research cannot provide conclusions regarding efficacy or safety” (p. 3). “There 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” (p. 83).

(Please note: The name “Sexual Orientation Change Efforts or SOCE” is applied generically by the American Psychological Association (2009) to *any* assistance given to persons with unwanted SSA, without distinguishing professional from pastoral and other caregivers.)

APA (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation [http://www.apa.org/search.aspx?query=Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation](http://www.apa.org/search.aspx?query=Report%20of%20the%20American%20Psychological%20Association%20Task%20Force%20on%20Appropriate%20Therapeutic%20Responses%20to%20Sexual%20Orientation) (Document option # 4)

- More recent studies, conducted similar to Shidlo and Schroeder’s, have made similar attempts to document that professional care for unwanted SSA is unacceptably harmful, but the methods and results of these studies fail to do so.

Rosik, C. H. (2014). The Reincarnation of Shidlo and Shroeder (2002): New Studies Introduce Anti-SOCE Advocacy Research to the Next Generation. *Journal of Human Sexuality*, 6, in press. Retrieve from <http://www.narth.com/#!reincarnation-of-shidlo--/c1tch>

6. Every approach to medical and mental health care has the potential for harmful – or at least unwanted - side effects. And no approach is guaranteed to work for any particular patient or client, even if “taken or used as directed.”

- Lambert (2013) reports that reviews “of the large body of psychotherapy research, whether it concerns broad summaries of the field or outcomes of specific disorders and specific treatments” lead to the conclusion that, while all clients do not report or show benefits, “psychotherapy has proven to be highly effective” for many clients (p. 176). Unfortunately, the research “literature on negative effects” also offers “substantial... evidence that psychotherapy can and does harm a portion of those it is intended to help.” These include “the relatively consistent portion of adults (5% to 10%) and a shockingly high proportion of children (14% to 24%) who deteriorate while participating in treatment” (p. 192). Such findings have been reported in the therapeutic and scientific communities for over three decades.

Lambert, M. (2013). The efficacy and effectiveness of psychotherapy. In Michael J. Lambert (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th edition), pp. 169-218. Hoboken, NJ: Wiley.

- In 2013, the World Medical Association (WMA) released a document which irresponsibly discredits professional attempts to assist clients in changing SSA and behavior. The Alliance for Therapeutic Choice and Scientific Integrity (Alliance) and NARTH Institute responds:

“The WMA statement is not so much a reflection on human sexuality as it is a clear attempt to discredit any and all professional attempts to assist clients who wish to modify same- sex attractions and behaviors. The Alliance and NARTH Institute observe that the WMA’s statement in many places lacks scientific integrity, sometimes makes conclusions that are no more supportable than speculation, and at times fails to provide adequate scholarly context... for its unsubstantiated linking of change-oriented psychological care with psychological harm. Any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general. Extensive research has shown that 5-10% of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates—sometimes exceeding 20%--have been reported for children and adolescents in psychotherapy (Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013). Deterioration rates would need to be established for professionally conducted change-oriented therapy significantly beyond 10% for adults and 20% for youth in order for claims of approach-specific harms to be substantiated. NARTH assumes the WMA knows that prevalence rates of success and harm for change-oriented psychological care are currently unknown, so it is difficult to avoid the conclusion that the WMA is targeting such care on ideological and not scientific grounds. “

Rosik, C. H. (2013). *NARTH Response to the WMA Statement on Natural Variations of Human Sexuality*, <http://www.narth.com/#!/world-medical-association---narth/c4c6>

- Other professional organizations also have irresponsibly emphasized the “potential for harm” that may be associated with receiving professional care for unwanted SSA and behavior, *without* clarifying that *all* forms of mental health services for *any* reason carry an level of “risk” and that there is no evidence that professional care for unwanted SSA carries a greater or unacceptable level of “risk.”

Sutton, P. M. (2014) *What Research Does and Does Not Say about the Possibility of Experiencing “Harm” by Persons Who Receive Therapeutic Support for Unwanted Same-Sex Attractions or “Sexual Orientation Change Efforts (SOCE)*. *Journal of Human Sexuality*, 6, in press. Retrieve from <http://www.narth.com/#!/iftc/c8me>

7. Persons who experience same-sex attraction and/or participate in same-sex sexual behavior are at significantly greater risk for a number of medical, psychological and relationship difficulties than persons who do not.

- “Researchers have shown that medical, psychological and relationship pathology within the homosexual community is more prevalent than within the general population. This is supported by studies that demonstrate the life-threatening risk-taking of unprotected sex, violence, antisocial behavior, higher levels of substance abuse, anxiety disorders, depression, general suicidality, higher levels of promiscuity and of non-monogamous primary relationships, higher levels of paraphilias (such as fisting), sexual addiction, personality disorders, and greater overall pathology among homosexual vs. heterosexual populations. In some cases, homosexual men are at greater risk than homosexual women and heterosexual men, while in other cases homosexual women are more at risk than homosexual men and heterosexual women. Overall, many of these problematic behaviors and psychological dysfunctions are experienced among homosexuals at about three times the prevalence found in the general population—and sometimes much more” (p. 4).

Summary of NARTH (2009): <http://www.scribd.com/doc/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1>; cf. Phelan, Whitehead & Sutton (2009), p. 53-87: <http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1> (complete references above).

- “People reporting SSA have a more widespread and intense psychopathological burden than probably any other group of comparable size in society, though college-age people may have more substance abuse problems. The reversed gender pattern of these conditions suggests some link with SSA itself” (Abstract, p. 125, cf. pp 150-ff).

Whitehead (2010). *Homosexuality and Co-Morbidity* (complete reference above).

8. There is no acceptable support for the common assertion that the greater incidence of psychological problems by persons who experience or gratify same-sex attraction, or who self-identify as “gay, lesbian or bisexual,” results from societal discrimination or rejection.

- Research suggests that - if it has any influence at all – it is *perceived - not objective - discrimination* which may be responsible for the increased suicidality experienced by many persons with same-sex attractions. Research also suggests that this and other effects of perceived discrimination result in part from the nonassertive, avoidant ways in which many persons who report SSA cope with their emotions.

Whitehead, N. E. (2010). **Homosexuality and Co-Morbidities: Research and Therapeutic Implications.** *Journal of Human Sexuality*, 2, 124-175. Retrieved from <http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2>

- “Very little evidence has been found for (the assertion that) gay psychological problems are a result of society's discrimination and rejection. Whether in tolerant and accepting environments or in intolerant ones, the incidence and type of psychological problems remain about the same” (Misconception 5; cf. Whitehead (2010), *Homosexuality and Co-Morbidity*, p. 161-164).

Whitehead, N. E. *Common misconceptions about homosexuality.* www.mygenes.co.nz/myths.htm

9. All persons with unwanted sexual minority experiences deserve the right to receive professional education, guidance, counseling, therapy and medical care. All medical and mental health professionals deserve the right to offer such care.

- “Organizational intolerance of and discrimination for receiving and offering professional care to understand, manage and resolve unwanted SSA – and other sexual minority concerns – if enacted in any national or international jurisdiction, would be a violation of human rights as recognized by the **Universal Declaration of Human Rights** (UDHR), retrieve from <http://www.un.org/en/documents/udhr/index.shtml#a11>, and the **Convention on the Rights of the Child** (CRC), retrieve from <http://files.meetup.com/3480872/Convention%20on%20the%20Rights%20of%20the%20Child%20.pdf>.

These include the rights of both adults and children to:

- (1) the full development of one's human personality (UDHR, #26; cf., CRC, Preamble, #18 & 29).
- (2) medical care and necessary social services (UDHR, #25; cf. CRC, Preamble, #24, 27, & 39).
- (3) freedom of thought, conscience, and religion (UDHR, #18; cf., CRC, #14, 30).
- (4) education and freedom of opinion and expression, which includes the freedom to hold opinions without interference and to seek, receive, and impart information and ideas through any responsible media (UDHR, #19; cf., CRC, #12, 13, & 17).
- (5) the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation (UDHR, #12; cf., CRC, Preamble, #3, 5, 16, 29, 34 & 36).

We therefore recommend to OSCE Participating States:

In light of the aforementioned fundamental rights upheld by the Convention on the Rights of the Child and the Universal Declaration of Human Rights:

- 1. To recognize and condemn intolerance and discrimination against sexual minorities who freely choose to receive help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity.**
- 2. To draft legislation to safeguard the freedom of medical and mental-health practitioners and educators to offer their professional guidance and therapeutic expertise to all people whose own sexual minority concerns are *unwanted* and who *freely* choose help in order to overcome or diminish their unwanted sexual attractions, orientation, behaviors, and/or identity. This includes minor children who themselves freely seek such services with the consent of their parents.**

We recommend to OSCE/ODIHR and OSCE Missions:

- 1. To be aware of and condemn intolerance and discrimination against sexual minorities who freely choose help in order to eliminate, diminish, or manage unwanted feelings, thoughts, behavior, and/or identity.**
- 2. To assist OSCE Participating States in monitoring and drafting legislation, with special attention to safeguarding the above-mentioned rights upheld by the CRC and the UDHR.**