1/31/2023 Rhoda Mehl Testimony HF16

My name is Rhoda Mehl, and I have been married to my Husband Pastor Daren Mehl for 17 years. We have two wonderful children, Sebastian and Esther. We are a family that wouldn't exist if it were not for the sanctifying grace of God through faith in Jesus Christ.

I met my husband when he was living as a gay man. We met each other through a guy friend Daren once dated, and who I was dating at the time.

We both came to renewed faith in Jesus Christ as our friendship grew. I was there when Daren was going through questioning his gay sexuality. I was there when he broke up with the guy he had dated for several years. I was there when Daren was hooking up with guys over and over and was conflicted in his faith about doing that.

Even though both of us knowing full well he was struggling with his sexual identity, Daren decided to pursue a relationship with me out of faith and love. I said yes, and we both stepped out in faith. I was there when Daren proposed to me at Valley Fair on stage in the theater in front of all my employees and his family. I was there when Daren married me as a gay identified man – having committed to believing that God called us to get married even though we weren't sure of our sexuality.

And here it is, the journey out of homosexuality. Jesus was Daren's conversion therapist. Let me say that again – in your terms – Jesus was Daren's "conversion therapist"

I was there to see the spiritual sanctification that Jesus did in Daren. I was there when Daren grew, month after month, into a godly man, watching as Daren forgave those who bullied him into a gay identity and asked God to affirm him in his authentic identity. I was there when God revealed to Daren God had given Daren a new heart and mind. I was there when Daren realized he no longer saw men as sexual objects to abuse but as brothers in Christ. I was there when Daren's heart toward himself believed that he was fully a man among men and not an 'other' type of man. I testify that God had truly changed his desires to be in alignment with holiness by grace through faith in Jesus Christ.

Daren is a changed man. He once was gay, and now he's not. The conversion from Gay to Straight was the work of God through sanctification by grace through faith in Jesus Christ.

Rhoda Mehl
Warroad, Minnesota

1/31/2023 Daren Mehl Testimony HF16

My name is Daren Mehl. Rhoda testified of the work of God by grace through faith in Jesus Christ to transform me from death to life, from a sinner to a saint, from a homosexual to a heterosexual.

What happened? God convicted me of sin and the consequences of it, and made clear His desire that I would be saved and reconciled to Him and made holy in Jesus Christ. I was personally convicted about the dehumanizing, emasculating, soul destroying, harmful, unbecoming, unloving, and sinful behavior of sodomy. I then dared to question my gay sexuality realizing that the sinful behavior was blocking my expression of love toward God, that I couldn't be sincere in obeying His commands if I kept on with sodomy.

That is what is being promoted by HF16. The idol of licentious sexuality. I repented of that idol.

Would a gay identified person be allowed to repent and be discipled by Jesus? No – because the truth of the bible which teaches sanctification through faith in Jesus Christ that changes evil desires for sodomy to be rightly ordered in holiness to heterosexuality is labeled as conversion therapy! HF16 makes it clear that Jesus is a conversion therapist and that following Jesus is a major form of conversion therapy and must be banned. Today, TODAY, Matthew Gretch is facing fines and jail time in Malta for testifying of Jesus setting him free from homosexualtiy, the charges against him is "advertising conversion therapy".

The "elephant in the room" is that HF16 has the effect of labeling the Christian faith as bigotry and harmful. The "expert APA" report on sexual orientation change efforts has framed the Christian faith as the 'social stigma' that causes harm to "The LGBT". Everyone supporting HF16 would agree. However, God's truth "The LGBT" is a term for a person stuck in the sin of Pride who are offered repentance and redemption unto restoration of their authentic heterosexual self as God designed for them. HF16 criminalizes God's design and will for people. It promotes pride as a social virtue and criminalizes humility before God. It tragically binds "The LGBT" to their sinful nature as they are not allowed to repent and follow Jesus, love God, and seek holiness and their authentic self through discipleship or therapy.

This bill will criminalize the ministry I am called to as a Pastor, and it would criminalize every parent who fosters a biblical identity in their children.

Jesus is the way the truth and the life. Those who believe in Jesus find life and freedom. Jesus does not lead to suicide, depression, or anxiety – Jesus delivers from them.
https://www.voiceofthevoiceless.info/notalktherapydoesntleadtosuicide

HF16 criminalizes the workmanship of God in our lives.

HF16 is tyranny against the soul, against free exercise of religion, and a violation of natural law and the Constitution. Those who support this bill must repent for their sin before God or face judgement.

HF16 would criminalize parents from counseling their child who is bullied into the gay identity, or worse groomed into a transgender identity, out of their confusion and into the truth of their Creator, Jesus Christ. This bill will criminalize the ministry I am called to as a Pastor, and it would criminalize every parent who fosters a biblical identity in their children. Don't lie and say this isn't true. You've brought up medical students and other "professionals" who are mandatory reporters. I know they will participate in discrimination against Christian parents because they think they are more virtuous than God in protecting children.

LGBT Ideology is not "Science"

The pillar of the 'born perfect' campaign is their false science and their appeal to authority of the APA. Yet we know that the APA has been taken over by a gay cabal (https://www.thisamericanlife.org/204/81-words) with a gay agenda (https://www.apa.org/about/division/div44), they've admitted as much. We all know in 2007 the APA rejected intelligent design in favor of the theory evolution. (https://www.apa.org/science/about/psa/2007/04/id)

In that moment the APA uncoupled their pursuit of truth, their "science", from the objective truth of Intelligent Design. By doing so they gave up any ability to determine what is "normal" or "intended" for mankind, as evolution can bring no purpose to mankind, it cannot define "normal". The APA have adopted a godless fake science that now explores the 'spectrum' of human experience. There is no more "normal" in the APA, except that which is "evidence based". A deadly euphemism for "probably true" in a godless worldview. They've given up the Creator and turned to the creation for "truth".

So after 50 plus years of rejecting God, we've slid into the gender "spectrum" the sexual orientation "spectrum" and even the neuro-diverse "spectrum". See – their science is missing the cornerstone of knowledge – Our Creator. Without the Creator – and intelligent design – there can be no diagnosis of "disorder". Without the Creator – there is no "order" - only "evidence" of what is.

Today the assumption in this room is that "science" represents truth, but truth absent knowledge of the Creator and intelligent design is just blind guessing. Today the 'evidence' before us is how mankind is sinful in NATURE and without GOD and His sanctifying power – we'll all progress to embrace that which is pleasurable in the moment but deadly. We'll exchange truth for a lie. We'll reject Love as defined by God and replace it with "love is love" which is defined by man.

Today the spirit of lawlessness is at work in this bill. This bill represents licentiousness, that is "freedom without any moral or material boundries". A word not often enough used today, it is straight from the pit of hell. "Do as you will" is the calling card of satan.

Today I call all you rebellious Democrats to repent and vote NO on this bill. You are currently practicing lawlessness.

For example, in the first hearing on this bill Rep Heather Edelson mentioned the "elephant in the room" and thereby admitted show KNOWS this is attacking religious freedom. She knows that

Christian discipleship exists on the internet to help people leave the LGBT lifestyle and she wants to stop it and label it is harmful and criminal.

For example, Rep Bierman knows that this bill is unconstitutional but doesn't care and knowingly breaks his oath to uphold the Constitution. He admitted this last year in the hearing. https://www.agapefirstministries.org/mnhf2156testimony

For example, The lawless democrat controlled ethics committee threw out the complaint that Bierman is breaking his oath, they too are lawless and working against our Constitution.

Lawlessness is cured by humility before God and punishing evil – not promoting it as this bill does. Our founding fathers understood that licentiousness breeds tyranny. And this bill is nothing except religious tyranny hiding behind a fake "science". You should at least be honest with the people, you want your religion to be the religion enforced by the state, rather than the truth of God, our Creator, and His Sovereign, Jesus Christ.

Righteousness, holiness, love, created order, eternity, fellowship with God, temptations, sin, living in the flesh, pride, lawlessness, reprobate mind, abomination, death, being chosen, conviction of sin, humility of spirit, godly sorrowful repentance, reconciliation, propitiation for sin, salvation, sanctification, redemption, fear of God, evangelism, discipleship, baptism, born again, testing and trials, living in the spirit, life abundantly, joy, peace, patience, kindness, goodness, LOVE.

These are all terms that the Christian learns in our faith. These are terms that will become criminal to teach the repentant homosexual. You stand against our Creator and His truth when you vote YES for HF16.

Pastor Daren Mehl
Warroad Community Church
Warroad, Minnesota

Psalms 2

Why are the nations in an uproar
And the peoples devising a vain thing?
The kings of the earth take their stand
And the rulers take counsel together
Against the Lord and against His Anointed, saying,
"Let us tear their fetters apart And cast away their cords from us!"
He who sits in the heavens laughs, The Lord scoffs at them.
Then He will speak to them in His anger
And terrify them in His fury, saying,
"But as for Me, I have installed My King Upon Zion, My holy mountain."
"I will surely tell of the decree of the Lord: He said to Me,
'You are My Son, Today I have begotten You.
Ask of Me, and I will surely give the nations as Your inheritance,
And the very ends of the earth as Your possession.
You shall break them with a rod of iron,
You shall shatter them like earthenware'"
Now therefore, O kings, show discernment;
Take warning, O judges of the earth.
Worship the Lord with reverence
And rejoice with trembling.
Do homage to the Son, that He not become angry, and you perish in the way,
For His wrath may soon be kindled.
How blessed are all who take refuge in Him!

1/31/2023

My name is Grace Poole. I'm from the Twin Cities where I lived openly as a lesbian for 16 years. I moved two and a half years ago just West of the Twin Cities because my life had changed when I met Jesus and I desperately needed a fresh start away from the old LGBTQ identity and community. They rejected my new life and identity as a heterosexual Christian.

I was quite a young woman when someone first labeled me as gay. That false rumor spread and soon most people I knew labeled me as gay as well. The truth is, I had never even had a romantic or sexual thought about girls. I only saw them as friends. People told me I was denying who I was. They said it was clear to them I was queer. I ended up living in shame under the gay identity and an inauthentic life for a long time.

Looking back now over 19 years ago, I see how the loudest voices bullied me and manipulated my thoughts, and formed a gay identity for me based on their biases. I wasn't strong enough, big enough, or loud enough to speak up to defend myself, deny their oppressive labels, or assert my authentic self. I didn't have a safe space.

Now I am speaking up. I am speaking up for all of those who aren't strong enough or loud enough to speak for themselves. I am speaking up for all of those who are bullied and manipulated based off of other's biases.

My life went from dark, lost, scared, angry and confused to finding an unspeakable joy, love like I have never known, and very much found. I was lost but I was found by the love of Jesus. " For the Son of Man came to seek and save the lost." Luke 19:10 NIV

I found myself one night, very late, on my knees, begging God to take this from me. I didn't want it anymore. I wasn't asking God to take my life. I was asking Him to take this need I had to be affirmed by others of who I was.

It didn't happen right away but the walls that I had built so high started to come down. I found a community of other Christians, and a church that supported me and loved me in my brokenness. They encouraged me as my life changed right before their eyes. They loved me in practical ways and came alongside me and told me that I belonged.

The more time that I spent reading the Bible and spent time with other Christians the faster the dominos of sadness, shame, fear, and hopelessness, they all just faded away. They were replaced with an incredible love and an unspeakable joy.

My life will never be the same because of the love of Jesus and a few college friends who loved me enough to hang with me while God worked in me. I found a community where I belong and where I have been able to find healing.

Just like the caterpillar ceases to exist when the butterfly emerges, so to it was with me. I am someone completely new, with a new perspective, and a new purpose. I can stand tall, and complete not dependent on who anyone else says that I should be. I know who I am and Who's I am.

Please vote no on this bill. There are so many others with a story like mine that have been bullied and manipulated. Give them the chance to find that unspeakable joy and love if they so choose. Don't force them to stay trapped in darkness and pain when some of them long to find healing and hope.

Gracie Poole
Annadale, MN

National Task Force for Therapy Equality

Report to the Federal Trade Commission

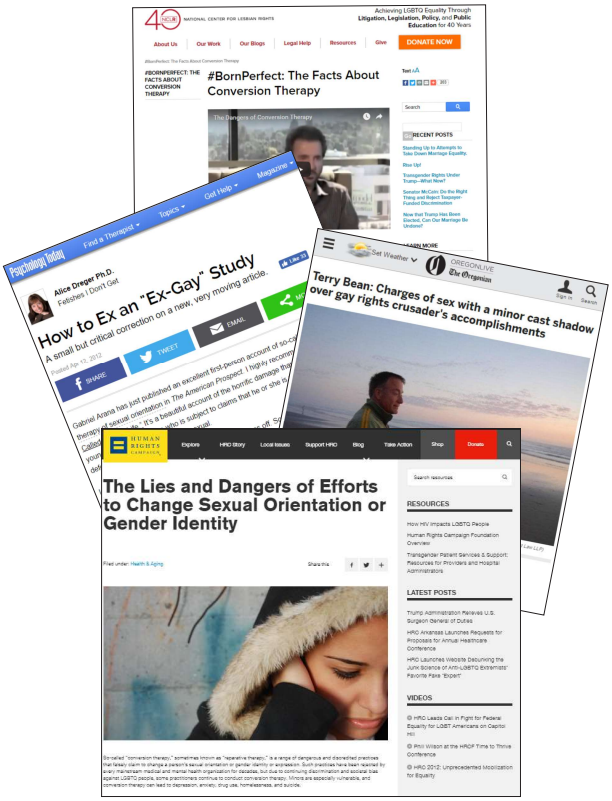
May 2, 2017

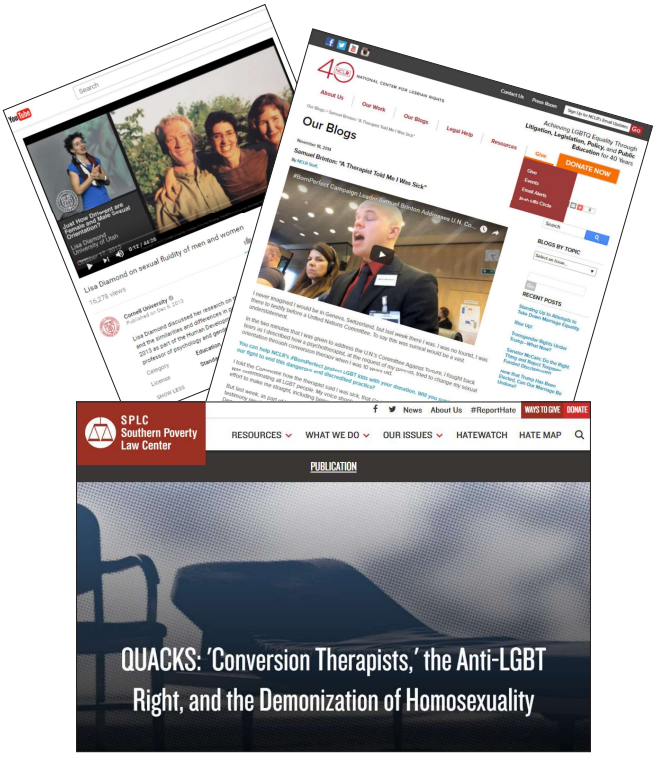
In Their Own Words

Lies, Deception, and Fraud

Southern Poverty Law Center, Human Rights Campaign, and the National Center for Lesbian Rights' Hate Campaign to Ban Psychotherapy for Individuals with Sexual and Gender Identity Conflicts

The National Task Force for Therapy Equality is a coalition of licensed psychotherapists, psychiatrists, physicians, public policy organizations, and psychotherapy clients/patients from across the United States of America. Their purpose is to secure therapy equality for clients that experience distress over unwanted same-sex attractions and gender identity conflicts





Contents

Executive Summary

In February 2016, the Southern Poverty Law Center (SPLC), Human Rights Campaign (HRC), and National Center for Lesbian Rights (NCLR) filed a complaint with the Federal Trade Commission (FTC) against People Can Change (now called Brothers Road), accusing the Virginia-based non-profit organization of committing consumer fraud, namely, by offering, marketing, selling, and performing services that purport to change a person's sexual orientation or gender identity, commonly referred to as "conversion therapy." This complaint was a part of the Respondents' ongoing effort to curtail the therapy rights of individuals, and their families, who experience sexual and gender identity conflicts by enacting legislation to ban licensed psychotherapy on the state and federal level.

This complaint prompted the National Task Force for Therapy Equality, a coalition of psychotherapists, psychiatrists, physicians, public policy organizations, and clients who experience unwanted same-sex attractions and gender identity conflicts, to launch a comprehensive investigation titled:

In Their Own Words — Lies, Deception, and Fraud: The Southern Poverty Law Center, Human Rights Campaign, and National Center for Lesbian Rights' Hate Campaign to Ban Psychotherapy for Individuals with Sexual and Gender Identity Conflicts

As this report will detail, the three Respondents have been actively working together for at least five years in a deceptive and fraudulent hate campaign with the goal of deceiving law makers on the state, federal, and international level to enact legislation to ban licensed psychotherapy for clients (minors) that experience unwanted same-sex attractions and gender identity conflicts. To date, six states and several cities and jurisdictions have passed such legislation into law, prompting several lawsuits across the country.

This report will demonstrate the following:

- The three Respondents have actively and knowingly engaged in deceptive and fraudulent marketing practices of the kind the FTC considers malicious, which are particularly deceptive and misleading to consumers and the general public. This complaint is pursuant to the FTC's definition of unfair practices, defined as those that "cause or are likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition" (15 U.S.C. Sec. 45(n)).
- The three Respondents have supported witnesses on the state, federal, and international level that have delivered unverifiable and fraudulent testimony in front of law-making bodies in the effort to persuade legislative action to ban psychotherapy. Through multiple examples, it has now been proven these witnesses have lied and engaged in a variety of deceptive practices on behalf of the Respondents' hate campaigns to ban psychotherapy.
- The three Respondents, through their marketing campaigns, are actively raising large sums of money in the effort to ban psychotherapy by using deceptive and fraudulent practices. These practices are misleading to the general public, and, as this report documents, it is highly unlikely that the three Respondents are unaware of the false and misleading nature of how their statements distort the facts and research around psychotherapy to help clients with sexual and gender identity conflicts. As such, they are knowingly misleading consumers in their efforts to profit from such activities.
- The three Respondents, through their marketing campaigns, have actively and knowingly distorted the research to promote efforts to ban psychotherapy for clients with sexual and gender identity conflicts, including misleading statements regarding the 2009 American Psychological Association Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation, as well as other research (e.g., Ryan et al., 2009). The three Respondents use these misleading statements to make false and misleading claims that psychotherapy is harmful and ineffective for minors who experience sexual and gender identity conflicts.
- The three Respondents, through their marketing campaigns, have actively distorted the scientific research in promoting the "Born Gay" hoax, a notion that has been disproved and refuted by organizations such as the American Psychological Association through their 2008 Position Statement and 2014 *APA Handbook of Sexuality and Psychology*. The Respondents have perpetrated this lie to further their respective political agendas, and in so doing, have raised untold sums of money from unsuspecting consumers and the general public.
- The three Respondents have also engaged in smear and defamatory attacks on licensed psychotherapists and faith-based ministries providing help and assistance to those who experience sexual and gender identity conflicts. Until recently, one of the Respondents (SPLC) included an interactive "Hate Map" that identified nearly 100 therapists and ministries on their website. The Respondent recently removed this map in the aftermath of the crime of Floyd Corkins, a gunman who was inspired by the SPLC's "Hate Map" to enter the Family Research Council in 2013 and attempt to murder conservatives.
- One of the Respondents (SPLC) was also reported to the Internal Revenue Service (IRS) in 2017 by the Federation for American Immigration Reform (FAIR) for engaging in practices of using "opinion-based smears and innuendos" as though they were educational while violating governmental regulations and using tactics that it claims shields it from liability lawsuits. The Respondent's blatant engagement in political activity is a clear violation of their 501(c) (3) status with the IRS, says the complaint.

By engaging in these deceptive and fraudulent practices, the National Task Force for Therapy Equality accuses the Respondents of perpetrating undue harm on millions of consumers and the general public, hundreds of licensed mental health providers, and thousands of clients and potential clients that experience sexual and gender identity conflicts. Because their hate campaigns have already resulted in therapy bans enacted in at least six states and several other cities and jurisdictions, this report respectfully requests the FTC to review these fraudulent and deceptive practices and to promptly order the Respondents to cease their activities in the effort to protect therapists, clients, consumers, and the general public from further harm. In addition, we respectfully request the FTC to order the three Respondents to issue press releases, correct inaccurate statements on their websites, and actively work with legislators across the United States to reverse legislation that has been passed into law so that further harm can be avoided.

As this report will detail, the three Respondents have been actively working together for at least five years in a deceptive and fraudulent hate campaign with the goal of deceiving law makers on the state, federal, and international level to enact legislation to ban licensed psychotherapy for clients (minors) that experience unwanted same-sex attractions and gender identity conflicts.

The National Task Force for Therapy Equality (NTFTE) respectfully requests that the Federal Trade Commission ("FTC") investigate and stop the libelous, slanderous, deceptive, and misleading actions of the Southern Poverty Law Center (SPLC), Human Rights Campaign (HRC), and National Center for Lesbian Rights (NCLR), which have made broad-sweeping claims of fraud and harm towards professional sexual orientation change therapies, and their clients.

I. INTRODUCTION

A. Formal Purpose of this Complaint

The National Task Force for Therapy Equality (NTFTE), the following licensed therapists, and the following therapy clients respectfully request that the Federal Trade Commission ("FTC") investigate and stop the libelous, slanderous, deceptive, and misleading actions of the Southern Poverty Law Center (SPLC), Human Rights Campaign (HRC), and National Center for Lesbian Rights (NCLR), which have made broad-sweeping claims of fraud and harm towards professional sexual orientation change therapies, and their clients.

In accordance with the substantial scientific and anecdotal evidence that demonstrates sexual orientation change is possible for some individuals, and the lack of accurate research to support the assertion that Sexual Orientation Change Effort (SOCE) therapy is fraudulent and/or harmful, the NTFTE, licensed therapists, and therapy clients who report successful change in sexuality support the complaint herein.

The actions of the SPLC, HRC, and NCLR seek to invalidate and end the practice of professional sexual orientation change therapies and will result in a denial of free speech of therapists and therapy clients, restraint of trade, loss of religious rights, and in some cases, may pose harm to the mental and emotional health of clients, who could experience depression, anxiety and/or suicide ideation due to a lack of available therapists who share their values and goals.

As such, we define the efforts of the SPLC, HRC, and NCLR as malice, and are particularly deceptive and misleading to consumers and the general public. This complaint is pursuant to the FTC's definition of unfair practices, defined as those that "cause or are likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition" (15 U.S.C. Sec. 45(n)).

We respectfully request that the FTC take enforcement action to end the actions of the SPLC, HRC, and NCLR, which seek to defame change therapies, change therapists, and their clients, or to render a judgment against the three organizations for their actions, which are deceptive and misleading to consumers and the general public. We also ask that the FTC require these organizations to cease publishing slanderous remarks about change therapies, change therapists, and their clients, and require them to cease and desist publishing all deceptive statements including those within their public speeches, social media, online videos, and on their websites.

B. Overview of the Southern Poverty Law Center (SPLC), Human Rights Campaign (HRC), and National Center for Lesbian Rights (NCLR)

Southern Poverty Law Center – Respondent

Respondent Southern Poverty Law Center ("SPLC"), located in Montgomery, Alabama (www.splcenter.org) is a multi-million dollar law firm, organized as a non-profit, committed to targeting and prosecuting SPLC identified "Hate" groups. Until recently, the SPLC included an interactive "Hate Map" that identified nearly 100 therapists and ministries that help individuals with sexual and gender identity conflicts. The Respondent recently removed this map in the aftermath of Floyd Corkins, a gunman that was inspired by the SPLC's "Hate Map" to enter the Family Research Council in 2013 and attempt to murder conservatives.[1] The SPLC LGBT Human Rights Project is dedicated to the fraudulent pseudoscience of proving genetic homosexuality and to profiting from alleged harm of falsely named "conversion therapy." The SPLC initiated the lawsuit of Ferguson v. JONAH, exploited recruited plaintiffs, biased court proceedings, and manipulated overly broad consumer fraud laws in a New Jersey State Court to target and persecute this organization.[2] In 2014, the Federal Bureau of Investigation removed the SPLC from the "Resources" page of its Civil Rights Division. An internal FBI e-mail seems to suggest that the decision to remove the SPLC from this list was prompted by a meeting with Congressional staffers, who expressed the concerns of the head of the Family Research Council (FRC), whose presence on the SPLC's "hate watch" list inspired Floyd Corkins the gunman that targeted the FRC in 2012 in order to "kill as many employees as possible."[3]

Human Rights Campaign – Respondent

According to their website (www.HRC.org) the Human Rights Campaign is located in Washington, D.C. and is "America's largest civil rights organization working to achieve LGBTQ equality. By inspiring and engaging individuals and communities, HRC strives to end discrimination against LGBTQ people and realize a world that achieves fundamental fairness and equality for all. The Human Rights Campaign envisions a world where lesbian, gay, bisexual, transgender and queer people are ensured equality and embraced as full members of society at home, at work and in every community." While HRC works to defend the rights of the LGBTQ community, they have actively worked to marginalize, defame, and discriminate against individuals that experience unwanted same-sex attractions and gender identity confusion. Until recently, they have distanced themselves from formal efforts to end what they label "conversion therapy" for minors. "However, in a February 14, 2017 press release on pending legislation in New Mexico to ban "conversion therapy," they stated: "NCLR and HRC have partnered with state equality groups across the nation to pass state legislation to end conversion therapy."[4]

National Center for Lesbian Rights – Respondent

Located in San Francisco, CA, the National Center for Lesbian Rights (NCLR) launched the #BornPerfect Campaign in June 2014 to end "conversion therapy in five years by passing laws across the country to protect LGBT kids from these dangerous practices, fighting in courtrooms to ensure their safety, and raising awareness." According to their website (www.nclrights.org), the NCLR "focuses on employment, immigration, youth, elder law, transgender law, sports, marriage, relationship protections, reproductive rights, and family law to create safer homes, safer jobs, and a more just world. Each year, NCLR shapes the legal landscape for all LGBT people and families across the nation through its precedent-setting litigation, legislation, policy, and public education. For more than three decades, NCLR has led historic cases, and it is still blazing trails in pursuit of justice, fairness, and legal protections for all LGBT people."

Until recently, the SPLC included an interactive "Hate Map" that identified nearly 100 therapists and ministries that help individuals with sexual and gender identity conflicts. The Respondent recently removed this map in the aftermath of Floyd Corkins, a gunman that was inspired by the SPLC's "Hate Map" to enter the Family Research Council in 2013 and attempt to murder conservatives.

Petitioner therapy clients include over 1,000 individuals and families who seek help from licensed professional therapists to heal trauma from sexual abuse, to resolve unwanted same sex attractions and/or gender identity conflicts, and to heal from the consequences of homosexual activity, including depression, anger, addiction, disease, and suicide.

II. THE PARTIES

A. Licensed Psychotherapists

Over 20,000 licensed petitioner therapists, psychiatrists, and physicians represented by the National Task Force for Therapy Equality.

B. Therapy Clients/Patients

Petitioner therapy clients include over 1,000 individuals and families who seek help from licensed professional therapists to heal trauma from sexual abuse, to resolve unwanted same sex attractions and/or gender identity conflicts, and to heal from the consequences of homosexual activity, including depression, anger, addiction, disease, and suicide.

C. Southern Poverty Law Center (SLPC)

D. Human Rights Campaign (HRC)

E. National Center for Lesbian Rights (NCLR)

III. WRITTEN AND VERBAL STATEMENTS FROM THE SPLC, HRC, AND NCLR

A. Applicable Law

Section 5 of the Federal Trade Commission Act ("FTC Act") prohibits unfair and deceptive acts and practices, including statements. The FTC considers whether there has been a rep-

1 Peters, C. (May 30, 2015). I was traumatized by the Southern Poverty Law Center's hate campaign against ex-gays. Retrieved online at: http://www.voiceofthevoiceless.info/?s-hate+map

2 L. Haynes, & C. LiMandri (2016). JONAH Case: The Time for Legal Protection for Sexual Orientation Change Efforts is Now. http://www.wnd.com/2016/02/sexual-orientation-change-efforts-under-attack/

3 Bennett, J. (2/3/2017). EXCLUSIVE: FBI Removed SPLC, ADL From Resources Pages Over 'Number Of Concerns'. Retrieved online at: http://dailycaller.com/2017/02/03/exclusive-fbi-removed-splc-and-adl-from-civil-rights-resources-pages-because-of-a-number-of-concerns/

4 Miller, H. (2/14/17). Bill to Protect LGBTQ Youth from "Conversion Therapy" Moves Through New Mexico Senate Committee. Retrieved online at: http://www.hrc.org/blog/bill-to-protect-lgbtq-youth-from-conversion-therapy-moves-through-new-mexic

resentation, omission, or practice that is likely to mislead the consumer. The FTC also asks whether the representation, omission, or practice is a "material" one. Neither an intent to deceive nor actual consumer harm is required to find an act deceptive under the FTC Act. The analysis focuses on the risk of consumer harm. Both express misrepresentations and implied misrepresentations are violations of the FTC Act. If a claim is likely to be misleading without qualifying information, the qualifying information must be disclosed in a clear and conspicuous manner. Clear and conspicuous disclosure is required. A disclosure can qualify or limit a claim to avoid a misleading impression; it cannot, however, cure a false claim.

SPLC, HRC, and NCLR's false and misleading spoken and written practices concerning professional psychotherapy for unwanted same-sex attractions/gender identity confusion is deceptive, contains material omissions, and does not objectively consider all the research that has been completed to date. Publishing false and misleading information will result in harm to consumers by infringing upon their right to accurate information. The Respondent's researched evidence shows no proven conclusions by any psychological association in the United States, and its citations of the American Psychological Association (APA) are misleading.

1. Assumption 1: Everyone who experiences same-sex attraction is born gay.

On the American Psychological Association's (APA) own website (www.apa.org) under sections dealing with causation of homosexuality, it clearly indicates there is no "gay gene" and that other biological studies are inconclusive. It states that causes for homosexuality are most likely a combination of genetic and environmental influences. In other words, no one can be certain of causation in terms of proof at this point in time. The APA's Position Statement in 2008 reads:

> 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; most people experience little or no sense of choice about their sexual orientation.[5]

2. Assumption 2: Sexual orientation and gender identity (SOGI) therapies are harmful and ineffective for minors who experience sexual and gender identity conflicts.

As a basis for many of their statements, the three Respondents make references to the American Psychological Association, specifically a report that was produced in 2009. On pages 83-85 of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation,[6] the APA concludes there is no proof of harm done to anyone undergoing sexual or gender identity (SOGI) therapies:

> 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.[7]

When it comes to the effectiveness of SOCE for children and adolescents, the APA Task Force said the following:

> There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation.[8]

Therefore, there is no evidence to conclude SOGI therapies are harmful or ineffective. The SPLC, HRC, and NCLR are distorting the research by publishing false and misleading information to the general public to achieve their respective political agendas. As will be demonstrated later in this report, the Respondents distort the research often, and in a variety of ways.

As stated above, there is not one single outcome-based study in the scientific literature of minors undergoing SOCE therapy to back up these claims. Thus, to cite these potential health risks of SOCE therapy for minors is false and misleading. All three of the organizations in this complaint have cited similar claims on their websites and published materials, and are therefore guilty of misleading consumers and the general public.

As this report will show, most individuals who experience same-sex attractions also experience change in sexual attraction, behavior, and identity toward or exclusively toward heterosexuality. Anecdotal claims of harm ignore the majority of individuals who can and do change, with or without the help of therapy.

B. SPLC, HRC, and NCLR's false and misleading spoken and written practices concerning professional psychotherapy are deceptive and contain material omissions, which result in harm to the consumers by infringing on their right to accurate information.

1. Origins of false and misleading statements in California State legislation

In 2012, gay activist organizations, including but not limited to, SPLC, HRC, and NCLR began working with politicians in the state of California to pass legislation to prohibit licensed mental health practitioners from helping minors who experience unwanted same-sex attractions or wish to change their sexual orientation.

On September 30, 2012, Governor Jerry Brown signed into law Senate Bill 1172, essentially outlawing the practice of sexual orientation change effort (SOCE) therapy for clients under the age of 18. In a press release from the Governor's office, Brown said the following of SOCE therapy: "These practices have no basis in science or medicine, and they will now be relegated to the dustbin of quackery." As justification for the law, SB 1172 said the following in Section B:

> Sexual orientation change efforts pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources. This is documented by the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation in its 2009 Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.[9]

Despite the claims of harm cited in SB 1172, the American Psychological Association Task Force did not actually provide scientific evidence to back up the 28 health risks listed above. In fact, none of these health risks have been documented in the scientific peer-reviewed literature outside of a few published and unpublished anecdotal reports from adults, none of which have studied SOCE therapy outcomes for minors.[10]

As stated above, there is not one single outcome-based study in the scientific literature of minors undergoing SOCE therapy to back up these claims. Thus, to cite these potential health risks of SOCE therapy for minors is false and misleading. All three of the organizations in this complaint have cited similar claims on their websites and published materials, and are therefore guilty of misleading consumers and the general public.

As this report will show, most individuals who experience same-sex attractions also experience change in sexual attraction, behavior, and identity toward or exclusively toward heterosexuality. Anecdotal claims of harm ignore the majority of individuals who can and do change, with or without the help of therapy.

2. Misleading Statements and False Claims of Harm and Therapy Torture

In May 2016, the Southern Poverty Law Center (SPLC) published a paper that was posted on their website and said the "National Gay and Lesbian Task Force reacted with alarm," and "warned that the ex-gay industry was under-mining the battle for LGBT rights by suggesting that homosexuality is a choice, not an unchangeable condition like skin color." Such a statement is meant to convey to the reader that sexual orientation is unchangeable, like skin color.[11] Over the years, the SPLC has said a number of deceptive and misleading statements

5 American Psychological Association. (2008). Answers to Your Questions For a Better Understanding of Sexual Orientation & Homosexuality. Retrieved online at: http://www.apa.org/topics/lgbt/orientation.aspx

6 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* Washington, DC: American Psychological Association.

7 Ibid, p. 83., note: this was for all populations, children/adolescents as well as adults.

8 Ibid, p. 85., note: the Task Force did not find any outcome-research for children/adolescents undergoing SOCE therapy and fails to include language in their report that specifically states this.

9 ftp://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1151-1200/sb_1172_bill_20120416_amended_sen_v97.html

10 Phelan, J., Goldberg, A., & Doyle, C.J. (2012). *A Critical Evaluation of the Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, Resolutions, and Press Release.* Journal of Human Sexuality, 4, 41-69.

11 Southern Poverty Law Center (SPLC) (May 2016). "Quacks: 'Conversion Therapists,' the Anti-LGBT Right, and the Demonization of Homosexuality," p. 9. https://www.splcenter.org/20160525/quacks-conversion-therapists-anti-lgbt-right-and-demonization-homosexuality

about therapy to help individuals with unwanted same-sex attractions and gender identity confusion:

> Not only does it (SOCE therapy) not work, it's harmful to LGBT people and their families. People who have undergone conversion therapy have reported increased anxiety, depression, and in some cases, suicidal ideation. It can also strain family relationships, because practitioners frequently blame a parent for their child's sexual orientation.[12]

We will discuss more examples of misleading statements in the SPLC's paper later in this document.

The National Center for Lesbian Rights (NCLR) has said similar outrageous and inaccurate statements:

> In the past, some mental health professionals resorted to extreme measures such as institutionalization, castration, and electroconvulsive shock therapy to try to stop people from being lesbian, gay, bisexual, or transgender (LGBT). Today, while some counselors still use physical treatments like aversive conditioning, the techniques most commonly used include a variety of behavioral, cognitive, psychoanalytic, and other practices that try to change or reduce same-sex attraction or alter a person's gender identity.
>
> Conversion therapy can be extremely dangerous and, in some cases, fatal. In 2009, the APA issued a report concluding that the reported risks of the practices include: depression . . . and a sense of having wasted time and resources.
>
> The risks are even greater for youth. Minors who experience family rejection based on their sexual orientation or gender identity face especially serious health risks. Research shows that lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were more than eight times more likely to report having attempted suicide, more than five times more likely to report high levels of depression, more than three times more likely to use illegal drugs, and more than three times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. [13]

As evidence to implicate SOCE therapy for minors, the NCLR refers to a study by Ryan et al. (2009), which equates poor health outcomes for LGBT youth as synonymous with therapy outcomes. This statement is a common misuse of research by the NCLR and other gay activists. They cite a study that attributes high levels of family rejection to increased health risks for sexual minority youth and report that these outcomes are attributed to or somehow associated with youth undergoing SOCE therapy. In fact, none of the outcomes in this study were attributed to youth undergoing SOCE therapy, nor did the study even discuss therapy.[14]

The Human Rights Campaign (HRC) has also made similar outrageous and unfounded claims:

> So-called "conversion therapy," sometimes known as "reparative therapy," is a range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression . . . Minors are especially vulnerable, and conversion therapy can lead to depression, anxiety, drug use, homelessness, and suicide.
>
> In February 2016, the Human Rights Campaign, National Center for Lesbian Rights, and Southern Poverty Law Center filed a consumer fraud complaint with the Federal Trade Commission (FTC) against People Can Change, a major provider of conversion therapy. The complaint alleges that People Can Change's advertisements and business practices which claim they can change a person's sexual orientation or gender identity constitute deceptive, false, and misleading practices and can cause serious harm to consumers, all in direct violation of Section 5 of the Federal Trade Commission Act.[15, 16]

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Not only do these misleading statements attribute SOCE therapy as causing depression, anxiety, drug use, homelessness, and suicide for youth, they falsely accuse People Can Change (now called Brother's Road) of being a "conversion therapy provider" when in actuality, Brother's Road is a peer-lead, non-therapeutic experiential weekend for adult men who experience unwanted same-sex attractions. They do not provide any form of psychotherapy to adults, and they do not work with minors.

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3. "Conversion Therapy Torture Camps" in New Jersey

In March 2013, the New Jersey Senate Health, Human Services, and Senior Citizens Committee held a three-hour hearing on a bill that would take away the rights of minors who experience unwanted same-sex attraction (SSA) to receive therapy from licensed mental health professionals. Representatives from gay rights organizations, including the Human Rights Campaign, Garden State Equality, and the Trevor Project, as well as several mental health associations, testified at length about the so-called dangers of "conversion therapy." While all of these organizations used misleading statistics and false statements to condemn SOCE, one testimony in particular stood out that was particularly fraudulent.

Brielle Goldani, a transgendered woman from Toms River, New Jersey, stated she was tortured at an Ohio-based "conversion therapy camp" in 1997. "Twice a week I was hooked up to electrodes on my hands," she said. "I, a child, was shocked repeatedly by people who had my parent's permission to torture me." Goldani claimed that the torture occurred at a "conversion camp" called "True Directions." "This is nothing more than legalized child abuse," claimed Goldani at the hearing.

According to the office of the Ohio Secretary of State and Attorney General, no such camp called "True Directions" has ever existed. In fact, the only trace of this camp is from a 1999 movie titled "But I'm a Cheerleader," starring drag queen RuPaul. In the film, the main character is suspected of being a lesbian by her family members, who then proceed to send her to a fictitious "conversion therapy" camp called "True Directions." Throughout the course of the film, two disgruntled gay men encourage the campers to rebel against the program and discover their true identities as gays and lesbians. The final scene of the film shows the main character's parents attending a Parents and Friends of Lesbians and Gays (PFLAG) meeting to accept their daughter's homosexuality.[17]

Later that spring, on May 6, 2013, representatives from Garden State Equality, New Jersey's largest gay rights organization, made further false and misleading statements at a press conference at the State Assembly House in Trenton, New Jersey.[18] At the press conference, representatives of Garden State Equality claimed that six other "conversion therapy torture camps" existed in Ohio (and other states) with similar names as "True Directions." Garden State Equality Executive Director, Troy Stevenson, was asked at the press conference where the alleged camps were located and their names, and promised to provide all members of the press corps the names of these camps right after the press conference. However, Stevenson failed to provide any of these details, even after multiple phone calls were made to his office.

It is important to note that state policy organizations such as Garden State Equality have worked very closely with the HRC, SPLC, and NCLR in their campaigns to make SOCE therapy illegal. They act as local liaisons, recruiting, prepping, and providing talking points to witnesses at committee hearings. In the experience of the NTFTE, the vast majority of witnesses recruited and ultimately those who testify in front of state legislatures have never undergone professional psychotherapy to resolve same-sex attractions or gender identity conflicts with a licensed mental health practitioner. They are typically gay-identified advocates of local and state gay activist organizations or work on behalf of medical and mental health associations within (and outside) the state that oppose SOCE therapy.

12 https://www.splcenter.org/issues/lgbt-rights/conversion-therapy

13 http://www.nclrights.org/bornperfect-the-facts-about-conversion-therapy/

14 Ryan, C., Huebner, H., Diaz, R.M., & Sanchez, J. (2009). *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults.* Pediatrics, 123,1.

15 Https://www.splcenter.org/sites/default/files/ftc_conversion_therapy_complaint_-_final.pdf

16 Http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

17 Doyle, C.J. (March 21, 2013). Transgendered 'woman' lies about therapy 'torture'. Retrieved online at: http://www.wnd.com/2013/03/transgendered-woman-lies-about-therapy-torture

18 Video footage of this press conference was obtained by representatives from Voice of the Voiceless, and can be found here: https://www.youtube.com/watch?v=LkDtlVTnHtI

In some cases, these witnesses are receiving compensation to attend and testify at hearings to promote therapy bans.[19] One prominent gay activist that has made a career from opposing SOCE therapy is Wayne Besen, Founder and Executive Director of Truth Wins Out. Besen has testified at state hearings to ban SOCE therapy, espousing the so-called horrors of "conversion therapy."[20] However, like many of his colleagues, Besen never received "gay to straight" therapy as he calls it, yet makes a living from his tabloid-style website that spins half-truths and lies about mental and medical health practitioners that work with clients who experience unwanted same-sex attractions and gender identity confusion.

Besen was one of nearly twenty witnesses that testified against SOCE therapy in the New Jersey General Assembly in the spring of 2013. Like Garden State Equality, Besen is not employed by the three organizations this report is filing a complaint against; however, the SPLC has acknowledged Besen for playing a major part in their efforts to end SOCE therapy. After this bill passed both houses in the New Jersey Legislature, Governor Chris Christie signed the bill into law on August 19, 2013.

4. Ice Baths in the State of Washington

In 2014, gay activists working with Democrat lawmakers in the state of Washington introduced HB 2451. The bill contained similar language to other legislation in California and New Jersey, and the tactics used by gay activists were very similar to that seen in New Jersey. Joseph Backholm of the Family Policy Council of Washington documented the almost unbelievable testimony of one witness:

> Proponents of the bill told stories about children being subjected to shock therapy and ice baths against their will. While that kind of aversive therapy is broadly condemned, there is little to no evidence that such therapy is done commonly if at all. The Washington State Department of Health said they have received no complaints about therapists performing coercive sexual orientation change therapy of any kind–much less ice baths and shock therapy–against the will of a client.[21]

The Senate ultimately killed this bill in 2014. However, in 2015, the same bill was introduced and passed by the House, only to be amended in the Senate to ban all therapy (not only therapy intended to reduce or eliminate homosexual feelings) that used methods such as electroshock or electroconvulsive therapy. This bill would keep "talk therapy" of any kind legal. But when that bill was sent back to the House for consideration, something remarkable happened. According to Joseph Backholm of the Family Policy Institute of Washington:

> The same people who spent the last year talking about the need to protect children from ice baths and shock therapy suddenly and strongly opposed a bill specifically designed for that purpose. What was the problem? The bill didn't go far enough. "It must restrict talk therapy", they said. Last year, not a word was uttered about the need to ban talk therapy because everyone was so horrified by the stories of involuntary shock therapy. All they talked about was the need to protect kids from child abuse. But now that they have been given the chance to stop involuntary shock therapy without the ability to regulate conversations… suddenly shock therapy wasn't such a big deal. There are two things we can learn from this recent development. First, the advocates of this bill have always been mostly interested in prohibiting conversations they dislike, not stopping physical forms of child abuse everyone opposes. The attempt to focus on stories of abuse was just part of the bait and switch. People suspected as much before, but now they have admitted it. Second, and maybe more importantly, the fact that they are willing to oppose a bill to stop child abuse in the hopes that they can pass a bill to ban conversations illustrates the depth of their conviction about this issue. From their perspective, telling kids same-sex attraction is not necessarily permanent is child abuse. The harm of involuntary shock therapy and the "harm" of a child being told change is possible are the same. If this tactic is successful now, it won't just be the therapists who are affected. If it were "child abuse" for a therapist to tell a child that sexual desires can be controlled or changed, why wouldn't it be child abuse for someone else to say the same thing?[22]

> *Besen never received "gay to straight" therapy as he calls it, yet makes a living from his tabloid-style website that spins half-truths and lies about mental and medical health practitioners that work with clients who experience unwanted same-sex attractions and gender identity confusion.*

> *Perhaps the most disturbing part of Shurka's testimony is that no one, not even the press, asked him why he didn't report the so-called "deaths" that occurred during his experience with Journey Into Manhood. Surely, if a crime, suicide, or homicide had occurred, a police report would have been filed. Yet, these stories continue to be recorded as testimony in front of state legislatures and printed in gay activist media outlets such as GAYRVA.com.*

This legislation was ultimately defeated again in 2015, was not introduced in 2016, and reintroduced again in 2017, only to fail once again.

5. "Not everyone walked out alive" in Virginia

The Commonwealth of Virginia has been a tough battle for gay activists to convince lawmakers to ban SOCE therapy for minors. Three years in a row, gay activists valiantly showed up to testify at the Republican-dominated legislature, only to see their bill die in committee. In 2016, one of the more shocking witnesses was Matthew Shurka, who is a prominent spokesperson for the NCLR's #BornPerfect campaign. During the late January committee hearing, Shurka (who allegedly went through "ex-gay therapy" from the age of 16-21) testified of the following (acccording to an article in a gay activist website):

> "I was in camp in Charlottesville," he said about a short stint in a conversion therapy camp called Journey Into Manhood located about 50 miles outside of RVA. "Not everyone walked out alive." Shurka has been involved in fighting ex-gay therapy since he abandoned the treatment, and he is unafraid to share some of the darker parts of his treatment, including "masturbation therapy" and being kept from his mother and sister for three years to avoid picking up feminine traits. He said folks like himself entered the treatments believing they could change, hoping to please their family and/or their faith, and were emotionally destroyed when they failed. "Every week someone is committing suicide or overdosing on drugs because they know they can't succeed," he said.[23]

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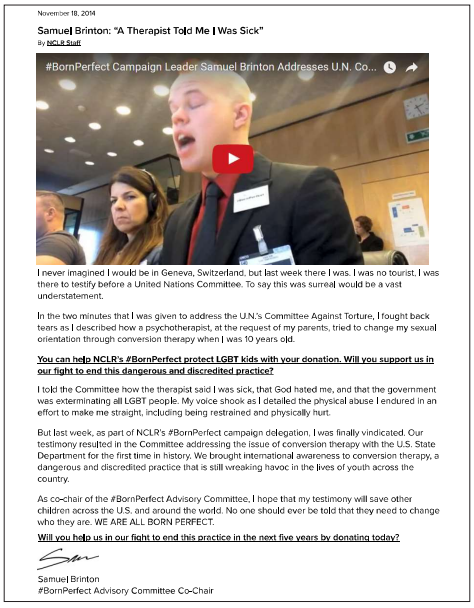
6. Samuel Brinton, Washington, D.C. and the United Nations

Another one of NCLR's prominent spokespersons to end SOCE therapy is Samuel Brinton, who has testified on multiple occasions in state legislatures and, in 2014, even traveled to Geneva, Switzerland to speak of his "therapy torture" at the United Nations. When Washington, D.C. considered (and ultimately passed) a bill to ban SOCE therapy for minors in 2014, one witness, Dr. Gregory Jones, included this quote (in part) from a TIME Magazine article telling Brinton's story:

> Sam Brinton says that his father first tried physical abuse to rid his young son of homosexual feelings. When that didn't work, Brinton's parents turned to something called reparative therapy. Some of the memories are hazy more than 10 years later, but Brinton does remember the tactics the counselor used. There was talk therapy, about how God disapproved, and there was aversion therapy, during which pictures of men touching men would be accompanied by the application of heat or ice. "It was pretty much mental torture," Brinton says. "To this day, I still have light pain when I shake hands with another male." [24, 25]

On November 14, 2014, Brinton spoke at the United Nations in Geneva, Switzerland to testify of the alleged abuse he suffered from an unnamed licensed therapist. According to CNSNews.com, Brinton "testified about the licensed psychotherapist who tied his arms down, wrapped his hands in hot copper coils, and stuck needles in his finger to channel electric shocks whenever he was shown a picture of men kissing."[26] Even more troubling, Brinton later authored (with the help of NCLR staff) a fundraising letter that was published on the NCLR blog of his experience at the United Nations:


November 18, 2014

Samuel Brinton: "A Therapist Told Me I Was Sick"

By NCLR Staff

#BornPerfect Campaign Leader Samuel Brinton Addresses U.N. Co...

I never imagined I would be in Geneva, Switzerland, but last week there I was. I was no tourist. I was there to testify before a United Nations Committee. To say this was surreal would be a vast understatement.

In the two minutes that I was given to address the U.N.'s Committee Against Torture, I fought back tears as I described how a psychotherapist, at the request of my parents, tried to change my sexual orientation through conversion therapy when I was 10 years old.

You can help NCLR's #BornPerfect protect LGBT kids with your donation. Will you support us in our fight to end this dangerous and discredited practice?

I told the Committee how the therapist said I was sick, that God hated me, and that the government was exterminating all LGBT people. My voice shook as I detailed the physical abuse I endured in an effort to make me straight, including being restrained and physically hurt.

But last week, as part of NCLR's #BornPerfect campaign delegation, I was finally vindicated. Our testimony resulted in the Committee addressing the issue of conversion therapy with the U.S. State Department for the first time in history. We brought international awareness to conversion therapy, a dangerous and discredited practice that is still wreaking havoc in the lives of youth across the country.

As co-chair of the #BornPerfect Advisory Committee, I hope that my testimony will save other children across the U.S. and around the world. No one should ever be told that they need to change who they are. WE ARE ALL BORN PERFECT.

Will you help us in our fight to end this practice in the next five years by donating today?

Samuel Brinton
#BornPerfect Advisory Committee Co-Chair

While Brinton's story sounds compelling, it has yet to be confirmed by any legitimate source or news outlet. According to a 2014 article, some pro-gay media tried to verify this report—and couldn't.[27] Even Wayne Besen, the most rabid "anti-ex-gay" activist, declared, "[U]ntil he [Brinton] provides more information to verify his experience, he makes it impossible for us to use him as an example. Indeed, it would be grossly irresponsible for us to do so."[28]

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> *This method is guilt by association, a sleight of hand, and it permeates the SPLC's paper. The high powered and well-financed lawyers and professionals who work for the SPLC do know the difference between criticism that applies to some individuals in a group but not the whole group, between religious practice and psychotherapy, and between licensed and unlicensed, and they do know what they are doing when they use this deceptive practice.*

7. SPLC Opinion-Based Smears and Innuendos Convey Sexual Orientation is Unchangeable, and Efforts to Change Do Not Include Aversive Therapy or Electric Shock But Regularly Lead to Suicide

In May 2016, the SPLC published a paper on its website titled: "Quacks: 'Conversion Therapists,' the Anti-LGBT Right, and the Demonization of Homosexuality."[29] The SPLC's "primary technique[s]" in its "Quacks" online paper are "opinion-based smears and innuendos" and "smearing by association, some of the same techniques that another organization, the Federation for American Immigration Reform (FAIR), documented in its complaint against the SPLC to the IRS."[30]

The Southern Poverty Law Center (SPLC) is a megalithic organization with a war chest of hundreds of millions of dollars. Since it has the means to hire a multitude of attorneys and any other consultants it wishes, one can be rather sure this report represents what the SPLC considers the best case it has to offer against therapy that is open to a client's goal of sexual orientation or gender identity (SOGI) change. With all the SPLC's resources, it should know whether its claims misrepresent current and scientifically accurate information or not.

The SPLC used the term "conversion therapy" about 250 times and never mentioned the terms actual psychotherapy providers use such as "sexual orientation change efforts (SOCE)," "sexual attraction fluidity exploration through therapy (SAFE-T)," or "heterosexual-affirming therapy." "Conversion therapy" is a term regularly used by opponents of real psychotherapy that is open to sexual orientation or gender identity (SOGI) change. Even unlicensed religious practitioners generally do not use the term "conversion therapy." They may speak of "religiously-mediated sexual orientation change efforts." Why avoid the actual terms in usage for the very subject of the paper?

The term, "conversion therapy" deceptively associates religious practice, "conversion," with the term appropriate for licensed professions, "therapy." Religious practices are not psychotherapy, and psychotherapy is not religious practice. The term "conversion therapy" also helps opponents lump unlicensed and licensed actors into one group. In this way, the SPLC can collect smears on a lay counselor, member of the clergy, or coach, none of whom are licensed psychotherapy professionals, and make it appear that such smears apply to all unlicensed and licensed actors.

This method is guilt by association, a sleight of hand, and it permeates the SPLC's paper. The high powered and well-financed lawyers and professionals who work for the SPLC do know the difference between criticism that applies to some individuals in a group but not the whole group, between religious practice and psychotherapy, and between licensed and unlicensed, and they do know what they are doing when they use this deceptive practice.

Anti-change therapy activists have scandals of their own. Some leaders have left, claimed to change their sexual orientation, and married an opposite sex partner. And there have been scandals of another sort. As Rosik said:

> I would find it contemptible if someone argued that because some highly influential gay rights leaders have recently been fighting charges of felony sodomy and sexual abuse with teenage boys and felony possession of child pornography that this must be the case for all such leaders.[31]

19 For example, Sam Wolfe of the SPLC and Alison Gill of the HRC testified in Washington, D.C. on June 27, 2014 in a hearing to ban "conversion therapy" for minors. See: http://lims.dccouncil.us/Download/29657/B20-0501-CommitteeReport1.pdf. Similarly, Samantha Ames of the NCLR testified in Geneva, Switzerland on November 11, 2014 in front of the United Nations. See: http://www.nclrights.org/genevavideo/

20 See: https://www.truthwinsout.org/pressrelease/2013/06/35675/

21 Balkholm, J. (February 14, 2014). "House Passes Ban on Life Change Therapy 94-4." Retrieved online at: http://www.fpiw.org/blog/2014/02/14/house-passes-ban-on-life-change-therapy-94-4/

22 Balkholm, J. (March 25, 2015). "Who Doesn't Oppose Child Abuse?" Retrieved online at: http://www.fpiw.org/blog/2015/03/25/doesnt-oppose-child-abuse/

23 Kutner, B. (January 26, 2016). Virginia legislator compares being gay to cancer as ex-gay therapy bill voted down in Senate subcommittee. Retrieved online at: http://www.gayrva.com/news-views/senator-compares-being-gay-to-cancer-as-ex-gay-therapy-bill-voted-down-in-ga-subcommittee/

24 Sprigg, P. (August 27, 2014). "Ex-Gay Therapy Debate: The Truth Matters." Retrieved online at: http://www.christianpost.com/news/ex-gay-therapy-debate-the-truth-matters-125479/

25 Steinmetz, K. (June 23, 2014). "The New Campaign to End Gay Conversion Therapy." Retrieved online at: http://time.com/2907989/bornperfect-gay-conversion-reparative-therapy/

26 Hunter, M. (November 14, 2014). "LGBT Activists: UN Should Classify Gay Conversion Therapy as Torture." http://www.cnsnews.com/news/article/melanie-hunter/lgbt-activists-un-should-classify-gay-conversion-therapy-torture

27 "The Mystery Surrounding "Driftwood's" Tortured Ex-Gay Survivor." (October 10, 2011). http://www.queerty.com/the-mystery-surrounding-driftwoods-tortured-ex-gay-survivor-20111010

28 Sprigg, P. (August 27, 2014). "Ex-Gay Therapy Debate: The Truth Matters." Retrieved online at: http://www.christianpost.com/news/ex-gay-therapy-debate-the-truth-matters-125479/

29 Southern Poverty Law Center, Quacks: 'Conversion Therapists,' the Anti-BGBT Right, and the Domination of Homosexuality, May 2016.

30 FAIR press release, April 5, 2017, http://www.fairus.org/news/fair-files-formal-exhaustive-complaint-with-the-irs-splc-violated-its-tax-exempt-status-repeatedly. The entire complaint can be found at http://www.fairus.org/DocServer/media/SPLC_Complaint.pdf. This complaint to the IRS about the SPLC found the SPLC used "opinion-based smears and innuendos" and "smearing by association". We found the same.

31 C. Rosik, My conversation with a typical opponent of professional therapies that include change, Journal of Human Sexuality, 2016, p. 8; J. Manning, J., Terry Bean: Charges of sex with a minor cast shadow over gay rights crusader's accomplishments. The Oregonian. Dec. 4, 2014, Retrieved from http://www.oregonlive.com/politics/index.ssf/2014/12/post_166.html; S. Mayes, Sex crime charges against Terry Bean will be dismissed; key witness won't testify. The Oregonian, Aug. 28, 2015, Retrieved from http://www.oregonlive.com/portland/index.ssf/2015/08/judge_dismisses_sex_crime_char.html; S. Mayes, With star witness absent, sex crimes case against Terry Bean and ex-boyfriend will be dismissed, The Oregonian, Aug. 28, 2015; http://www.oregonlive.com/portland/index.ssf/2015/08/judge_dismisses_sex_crime_char.html; K. Willson & N. Jaquiss, Terry Bean's problem: A prominent Portlander fights for his reputation after a love affair goes wrong. Willamette Week. June 3, 2015, Retrieved from http://www.wweek.com/portland/article-22648-terry-beans-problem.html; V. Ho, S.F. gay rights advocate sentenced for child porn. SFGATE,

The SPLC itself specifically has the scandal that it has targeted organizations of traditional values on a hate map leading to a gunman opening fire at the Family Research Council.[32] We doubt the SPLC would accept the accuracy of their smear-by-innuendo-and-association method if it were applied to itself.

The SPLC conveys deceptive perceptions indirectly not only about individuals who provide religious practices or professional psychotherapy. It also uses indirect methods to purvey false information about sexual orientation such as the falsehood that it cannot change. Here are some examples.

> A Pew Research Center poll finds that 51% of Americans do not believe that gay men and lesbians can change their sexual orientation, while 36% think they can. Answering the same question for Pew a decade earlier, in 2003, 42% said sexual orientation could be changed and 42% said it could not.[33]

> The National Gay and Lesbian Task Force...warned that the ex-gay industry was undermining the battle for LGBT rights by suggesting that homosexuality is a choice, not an unchangeable condition like skin color.[34]

The SPLC is careful not to put the generalization into its own mouth that sexual orientation never changes or is like skin color. Instead, it always presents the assertion from the mouths of others. There is a very good reason it is so careful. Research has established that the assertion is false. The organization may think if it cannot be pinned with actually stating a falsehood itself, it cannot be accused of being a purveyor of a falsehood. Thus, the SPLC shields its misrepresentations behind the assertions of others throughout the paper.

The SPLC is careful not to put the generalization into its own mouth that sexual orientation never changes or is like skin color. Instead, it always presents the assertion from the mouths of others. There is a very good reason it is so careful. Research has established that the assertion is false.

We will document that the American Psychological Association (APA) says in the *APA Handbook of Sexuality and Psychology* (2014) (*APA Handbook* or *Handbook*) and other researchers show that sexual orientation changes for many who experience same-sex attractions. In addition, the co-editor-in-chief of the *Handbook* (Dr. Lisa Diamond) has been telling political activists since 2008 to stop the "born-that-way-and-can't-change false claim" because it harms those who change—most same-sex attracted individuals, as we will also later document. Yet the SPLC has continued to propagate this deception.

The SPLC paper also conveys the impression that sexual orientation is dichotomous, that is, that it predominantly comes in two types—"gay" or "straight," barely acknowledging bisexuality. We will show that the *APA Handbook* says this portrayal is false; the vast majority of same-sex attracted individuals are also attracted to the opposite sex, and those who are exclusively same-sex attracted are the minority. We will substantiate that the majority of individuals who are both-sex attracted experience changes in their sexual attraction, behavior, and identity self-label—all three. This is the case for both men and women and for both adolescents and adults. Most of their change is toward or to exclusive opposite-sex attraction. We will substantiate all of this.

The term "bisexual" is used only 2 times. In one of the two uses of the term bisexual, the paper says Ted Haggard, leader of the National Association of Evangelicals, had "intensive counseling with senior evangelicals for three weeks," was pronounced "completely heterosexual" by one of them, but later said "that if he were 21, he would consider himself bisexual."[35] We would question what would be accomplished in three weeks of "intensive counseling" with an apparently unlicensed counselor in any case. But the SPLC seems to infer that if someone were to change from exclusive homosexual attraction to bisexual attraction, and did not change to exclusive heterosexual attraction, he would not have experienced sexual orientation change.

As we will show, most researchers and the *APA Handbook* would consider a change from exclusively homosexually attracted to bisexually attracted to be sexual orientation change. Even a change of one point on a five point continuum from exclusive heterosexual to mostly heterosexual to bisexual (attracted about equally to both sexes) to mostly homosexual to exclusive homosexual is considered change in modern research. Further, a change to bisexual or mostly heterosexual would allow an individual to live in a heterosexual relationship in accordance with the individual's desire.

The SPLC also leaves the reader with the impression that contemporary licensed mental health professionals generally claim they can make everyone go from exclusively gay to exclusively straight. However, licensed mental health professionals generally do not claim they can make anyone do anything, but they can assist individuals in the work they do in psychotherapy, and some individuals, though not all, make a significant and meaningful change through therapy.

The SPLC conveys the impression that no can go from exclusively same-sex attracted to exclusively opposite-sex attracted. Research shows some do make that kind of change, as we will document.

The SPLC also leaves the reader with the impression that contemporary licensed mental health professionals generally claim they can make everyone go from exclusively gay to exclusively straight. However, licensed mental health professionals generally do not claim they can make anyone do anything, but they can assist individuals in the work they do in psychotherapy, and some individuals, though not all, make a significant and meaningful change through therapy.[36]

The SPLC also leaves the reader with the impression that therapy that is open to change harms many people. However, there is no scientific evidence that meets scientific standards for that claim, again made through the mouths of others whom the SPLC quotes. The "Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation" for the APA in 2009[37] said it was unable to conclude from scientific evidence whether gay affirmative therapy or therapy that is open to a client's goal of change is safe or effective.[38]

The vast majority of the SPLC paper is not about professional psychotherapy; it is about religious support groups, but the reader gets the impression that all of the tabloid smears of religious support groups apply to licensed professional psychotherapists. The following are examples of the SPLC's presentations in its paper of what some individuals believe about whether sexual orientation can change through religious support groups. These examples have the effect of conveying to the reader that sexual orientation is immutable or never changes through religiously-mediated practices and through professional psychotherapy.

> John Paulk said that he did not believe that sexual orientation change was possible. He also said: "I do not believe that reparative therapy changes sexual orientation; in fact, it does harm to many people."[39]

> Michael Bussee, one of the 5 co-founders of Exodus International, said: "'I never saw one of our members or other Exodus leaders or other Exodus members become heterosexual' and added that it had harmed many people."[40]

Here are some quotes from an interview with Alan Chambers, former leader of Exodus International, whom the SPLC quotes extensively:

> Alan Chambers...led his board to close down the largest religiously based conversion therapy group in the country.[41]

> You've said that trying not to be gay is 'one big excruciating struggle, because it is impossible.'[42]

> ...I publicly denounced reparative therapy in 2012 after repeated calls from reparative therapists offering me free counseling to 'cure' me of my same-sex attractions.[43]

The term Reparative Therapy (RT) appears here. Therapy that is open to change generally is not a form of therapy but a therapist's openness to a client's goal of change using any

March 6, 2014; Retrieved from http://www.sfgate.com/crime/article/S-F-gay-rights-advocate-sentenced-for-child-porn-5292163.php

32 Cratty, C & Pearson, M. (February 7, 2013). DC shooter wanted to kill as many as possible, prosecutors say. Retrieved online at: http://www.cnn.com/2013/02/06/justice/dc-family-research-council-shooting/ possible, prosecutors say

33 Ibid., p. 35.

34 SPLC, 2016, p. 9.

35 SPLC, 2016, p. 34.

36 What Research Shows: NARTH's Response to the APA Claims on Homosexuality (Summary), p. 1, Family Watch International, http://www.familywatchinternational.org/fwi/NARTH_what_research_shows.pdf; The summary was of a full article, J. Phelan, N. Whitehead, & P.M. Sutton, 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, 2009, Journal of Human Sexuality, 1: 1-121. Available at https://media.wix.com/ugd/ec16e9_04d4fd5fb7e044289cc8e47dbaf13632.pdf

37 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, Washington, DC: American Psychological Association.

38 Ibid., p. 3, 42, 83.

39 Ibid., pp. 9, 10-11, 12.

40 Ibid., p. 10.

41 Ibid., p. 11-12.

42 Ibid., p. 47.

43 Ibid., p. 46.

contemporary form of talk therapy. RT, however, is a specific form of therapy pioneered by the late Dr. Joseph Nicolosi. Nicolosi laid out RT in his book, *Shame and Attachment Loss: The Practical Work of Reparative Therapy*.[44]

Nicolosi considered reparative therapy appropriate for about 80% of men who seek professional psychotherapy for unwanted same-sex attraction. The SPLC uses the term RT frequently and as a synonym for any effort to change sexual orientation, even though they quote Chambers as correctly designating RT as a type of professional psychotherapy that not all therapists who are open to change use. By knowingly misusing the term, the SPLC emphasizes that some therapists think there could be something in same-sex attractions to repair, a possibility the SPLC denies, even though the APA acknowledges trauma could be a potentially causal factor of same-sex attractions because research has shown that,[45] and even though excellent research shows absence or loss of a biological parent—an attachment loss, especially the loss of the parent of the same sex as the child, is potentially causally related to same-sex attractions.[46]

In this interview, Chambers reportedly said there were about 30 therapists in Exodus, and about 10% focused on RT, hence about 3 therapists focused on RT then. Therefore, according to the SPLC's report, only 30 members, or a tiny number of Exodus members, actually were licensed mental health professionals providing therapy that is open to change, 3 of which did RT. Activities of Exodus members were not representative of professional sexual orientation change efforts. Also, notably, by the SPLC's report of Chambers own words, Chambers never experienced RT or probably any professional therapy that is open to a goal of change. Therefore, Chambers is not an example of a therapy failure. Nicolosi published his book on RT in 2009. He was still training a handful of people. Chambers did not know enough about it and did not try it.

It is possible that the men who gave their opinions that no one changed were using the erroneous model that sexual orientation comes in two discreet categories rather than a continuum, so if any amount of same-sex attraction remains, they might make the interpretation that no sexual orientation has occurred.

It is possible that the men who gave their opinions that no one changed were using the erroneous model that sexual orientation comes in two discreet categories rather than a continuum, so if any amount of same-sex attraction remains, they might make the interpretation that no sexual orientation has occurred.

It is also possible that the men who testified that neither they nor anyone changed simply believed sexual orientation never changes for anyone, with or without therapy. A 2014 study gained insight into non-heterosexuals who held such a belief. These researchers studied spontaneous change, not change through therapy. In their non-representative study of non-heterosexual young adults, the researchers found, unsurprisingly, that the majority reported they had experienced spontaneous sexual attraction fluidity, some of them more than once. What was interesting was that the minority who had not experienced sexual attraction fluidity themselves, especially among men, more often believed sexual orientation is not changeable for all non-heterosexuals, contrary to findings in their study and in research broadly as we will later show.[47]

Alan Chambers and some others said they did not change through religiously-mediated efforts and believed no one else did either. In the case of Alan Chambers, the former president of Exodus International, his view also was contrary to actual research specific to Exodus. There is a prospective, longitudinal study on religiously-mediated sexual orientation change efforts that was conducted with individuals who were participating in some programs of member organizations of Exodus. It has been published in a book and a peer reviewed journal.[48] The study showed that some individuals diminished their same-sex attraction, some

There is no credible scientific evidence that therapy that is open to change leads to harm, as the APA Task Force Report said in 2009, yet the SPLC repeatedly conveys it. The assertion of "leading with grim regularly to suicide" is a particularly egregious misrepresentation of therapy that is open to change provided by licensed mental health professionals.

also developed heterosexual attraction, and some did not change. Out of all the subjects in the sample, there was one who reported change and later said he did not change. When Chambers took a position generalizing from his experience to the supposed experience of all members, he was wrong. Member organizations correctly disagreed with Chambers, left him, and formed new organizations (specifically, Restored Hope Network and later, Hope for Wholeness), effectively closing him down within a year of his taking his erroneous stand.

In addition to arguing indirectly that sexual orientation cannot change generally, and cannot change in therapy, the SPLC makes a claim coming from its own mouth directly that efforts to change sexual orientation through therapy are harmful. "The 'science' examined here actively harms people, leading with grim regularity to suicide, depression and an array of self-destructive behaviors."[49]

There is no credible scientific evidence that therapy that is open to change leads to harm, as the APA Task Force Report said in 2009, yet the SPLC repeatedly conveys it. The assertion of "leading with grim regularly to suicide" is a particularly egregious misrepresentation of therapy that is open to change provided by licensed mental health professionals.

The SPLC also said: "Leelah Alcorn, 17-year-old transgender girl in Ohio, commits suicide.... her parents... forced her to go to a Christian-based conversion therapy program."[50]

Leelah's suicide note did not say her parents "forced her to go to a Christian-based conversion therapy program." It says the parents provided therapy from Christian therapists." The SPLC merely projects that onto the story, or assumes that all Christian counselors do "conversion therapy," which, of course, is far from the truth, since most have not been trained in it.

Even if Leelah's therapist were so trained, we believe the therapist would not do that kind of work with Leelah. Leelah said in her note that she did not want therapy to change her gender identity. A contemporary licensed professional psychotherapist, Christian or not, who is open to a client's goal of change in gender identity would accept that Leelah did not have a goal of change in gender identity and would not pursue that therapy goal with her. Contrary to what opponents regularly say, therapists open to change do not coerce a therapy goal.

The suicide note also cites disappointment in peers, saying, "I finally had my friends back. They were extremely excited to see me and talk to me, but only at first. Eventually they realized they didn't actually give a s**t about me, and I felt even lonelier than I did before. The only friends I thought I had only liked me because they saw me five times a week. After a summer of having almost no friends...." Leelah reports multiple stressors.

The SPLC implies from one sensational and questionable story that therapists who are open to a client's goal of change have clients' suiciding right and left. There are more examples of statements in the SPLC paper show their use of innuendo to misrepresent therapy open to sexual orientation or gender identity change.

The SPLC says: "[E]lectric shock therapy...has virtually disappeared at this point."[51]

We note that even the SPLC can no longer assert SOCE uses an electric shock method, but still brings it up to keep the association ongoing. Electric shock was an experimental and small part of mainstream behavior modification therapy in the 1960's to early 1980's that was not created just for unwanted sexual behaviors. It was used for other unwanted behaviors such as smoking cessation and control of alcohol abuse.[52]

Another example from the SPLC is:

44 J. J. Nicolosi, Shame and Attachment Loss: The Practical Work of Reparative Therapy, Downers Grove, Illinois: IVP Academic, 2009.

45 B. Mustaky,, L. Kuper, and G. Geene, Chapter 19: Development of sexual orientation and identity, In Tolman, D., & Diamond, L., Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches, 2014, Washington D.C.: American Psychological Association.

46 Frisch, M. and Hviid, A., Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes, Archives of Sexual Behavior, 2006,35:533-547; Francis, A. M., Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 2008, 45 (4):371-377, DOI:10.1080/00224490802398357; J.R. Udry & K. Chantala, Risk factors differ according to same- sex and opposite-sex interest. Journal of Biosocial Science, 2005, 37:481–497, http://dx.doi.org/10.1017/S0021932004006765.

47 Katz-Wise, S.L., & Hyde, J.S. (2014). Sexual Fluidity and Related Attitudes and Beliefs Among Young Adults with a Same-Gender Orientation. Arch Sex Behav. 2015 Jul; 44(5):1459-70.

48 S. L. Jones & M. A. Yarhouse, Ex-Gays? A Longitudinal Study of Religiously Mediated Change in Sexual Orientation, 2007, Downer's Grove, IL: InterVarsity Press; S. L. Jones. & M. A. Yarhouse, A Longitudinal Study of Attempted Mediated Sexual Orientation Change. Journal of Sex & Marital Therapy, 2011, 37:5, 404-427.

49 SPLC, 2016, p. 4.

50 K. Corcoran & C. Spargo, Suicide note of 17-year-old transgender girl is deleted from her Tumblr page after her Christian parents demand message blaming them for her death be removed, Jan. 3, 2015, http://www.dailymail.co.uk/news/article-2895534/Heartbreaking-suicide-note-17-year-old-transgender-girl-DELETED-Tumblr-page-candlelit-vigils-held-honor.html

51 SPLC, 2016, p. 29.

52 A. D. Byrd & J. E. Phelan, Facts and myths on early aversion techniques in the treatment of unwanted homosexual attractions (no date),https://www.narth.com/aversion-techniques-

Historically, attempts to 'cure' gay people of their homosexuality have been marked by real horror stories—the use of castration, shock therapy, brain surgery, aversion therapy, the implantation of a heterosexual man's testicles and more.[53]

None of this bears any resemblance to contemporary professional therapy by licensed professionals, but there is little doubt that reporting this is intended to create such an association in the mind of the reader. By saying electric shock therapy and aversion therapy are historical, that is, not current, the SPLC is creating a current association between electric shock and archaic forms of medicine with contemporary talk therapy.

What the SPLC has actually established inadvertently is that even the SPLC—a staunch opponent of therapy that is open to change, with all its resources to research the matter and with its high motivation to find every possible flaw, acknowledges that such therapy does not use electric shock therapy or aversion therapy.

The SPLC also acknowledges a small number of researchers who had something positive to say about change therapy. Given that there are over 600 research publications, mostly peer reviewed, that span 125 years, the SPLC is quite minimalistic. These researchers pose a problem for the SPLC's disparagement of therapy that is open to change. We will illustrate how the SPLC deals with them.

Even Masters and Johnson, the pioneering sexologists who were the first to show that homosexuality is common, claimed that gay people could be converted.[54]

Again, the inappropriate term "converted" falsely associates professional psychotherapy with religious practice in the mind of the reader. This is a misrepresentation. Saying only that the researchers "claimed" same-sex attracted individuals can change is an understatement. Masters and Johnson actually published research showing they had a high success rate at sexual orientation change therapy, using the behavioristic methods of their day (but not electric shock), that were similar to the methods by which Alfred Kinsey, arguably the father of the scientific study into homosexuality and himself a bisexual, also successfully helped homosexual men change sexual orientation.[55]

Notably, the SPLC embedded Master's and Johnson in the context of truly archaic medical practices such as an experiment with a testicle transplant, an "icepick" lobotomy, convulsive therapies using drugs, and Nazi experiments, as though these have any bearing on licensed mental health professionals using contemporary talk therapies. Clearly, the purpose is to create associations in the readers' minds that flagrantly misrepresent contemporary therapy and distract the reader from actual research showing change therapy that is safe and effective.

Sigmund Freud is also mentioned:

> But it was Sigmund Freud, the father of psychoanalysis, whose ideas about homosexuality, developed in the first decades of the 20th century, formed the basis of what most conversion therapists today believe. Although Freud did not demonize gay people...he did see homosexuality in both men and women as a former arrested psychosexual development...the triadic family... A closely related theory blames early childhood trauma like sexual molestation... Today, the consensus of the vast majority of psychologists, psychiatrists and other counselors is that the model is entirely false.[56]

This passage conveys that the link between childhood trauma like sexual molestation and same-sex attractions is a false model. The APA takes a position that sexual variations are normal, but since its 2014 *Handbook*, at least, is not consistent with that view. The *APA Handbook* said there is a potentially causal link between documented cases of childhood molestation and having a same-sex relationship.[57] The *APA Handbook* also says there are "psychoanalytic" factors in same-sex attraction.[58] Excellent research shows there is also a potentially causal link between same-sex attraction, behavior, and self-label identity and absence of a biological parent, especially the parent of the same-sex as the child, as through death, divorce, end of

53 Ibid., p. 38.
54 Ibid., p. 7.
55 W. Pomeroy, Dr. Kinsey and the Institute for Sex Research, 1972, N.Y.: Harper and Row, Pub., pp. 72-75.
56 Op cit.
57 Mustanski, Kuper, & Greene, 2014, 1:609-610.
58 Rosario & Schrimshaw, 2014, 1:583, in APA Handbook.

Again, the inappropriate term "converted" falsely associates professional psychotherapy with religious practice in the mind of the reader.

Through this illustration and others, it is clear that the SPLC is a bully that tries to destroy volunteer-run religious support groups and psychotherapy for victims of sexual molestation and parent loss linked to same-sex attractions through suppressing, denying, and misrepresenting accurate scientific information and through viciously perpetrating falsehoods and deception.

parent co-habitation, or unknown paternity, and especially during the first six years of life and, for girls, in the case of a mother's death during adolescence. Denying these realities suppresses knowledge from individuals who have been injured and stand to benefit from accurate knowledge.

Another religious support group is brought up as the SPLC focuses on its lawsuit against JONAH (Jews Offering New Alternatives to Healing):

> The judge in the case barred almost all testimony from the six experts proffered by the defendants, saying that 'the theory that homosexuality is a disorder is not novel but—like the notion that the earth is flat and the sun revolves around it—instead is outdated and refuted.'[59]

The SPLC makes much of its victory over JONAH. JONAH was a two volunteer non-profit dependent for its defense on the pro bono services of a small law firm going up against the SPLC with its multitude of attorneys and probably quarter of a billion dollar resources. As a non-profit, JONAH simply engaged in no commercial activity, a requirement to be covered by the Consumer Fraud Act. JONAH's attorney and a co-author summarized:

> The Court allowed the New Jersey Consumer Fraud Act (CFA) to be applied to a religious organization and a non-profit organization for the first time ever, and allowed recovery for non-economic damages, even though the New Jersey CFA specifically disallows such recovery. In retrospect, this was the first sign that the lawsuit had a pre-determined outcome.[60]

The Court conducted the trial on the assumption that same-sex attraction, unlike seemingly every other aspect of human experience, is remarkably never affected by trauma. As we have said and will later document, however, research shows potentially causal links between childhood sexual molestation and parent loss with same-sex attraction.[61]

Through this illustration and others, it is clear that the SPLC is a bully that tries to destroy volunteer-run religious support groups and psychotherapy for victims of sexual molestation and parent loss linked to same-sex attractions through suppressing, denying, and misrepresenting accurate scientific information and through viciously perpetrating falsehoods and deception.

The SPLC also reports research of another famous clinician and researcher:

> The NARTH Institute/Alliance for Therapeutic Choice presents 'initial data' from a longitudinal study of 102 psychotherapy patients at NARTH founder Joseph Nicolosi's Thomas Aquinas Psychological Clinic. Nicolosi and Alliance President Carolyn Pela claim that 12 months of data show 'statistically significant reductions in distress and improvements in well-being, significant movement toward heterosexual identity, and significant increases in heterosexual desires and thoughts with accompanying significant decreases in homosexual thoughts and desires."[62]

This study is being conducted to meet the recommendations of the APA Task Force in 2009 for research that can show that therapy causes sexual orientation change and is safe. The SPLC has to include this research so as not to be embarrassed by critics pointing it out and so as not to be accused of not offering other views to the reader. Ironically, the SPLC surrounds the study with a chorus of unsupported opinions that SOCE is "potentially harmful" in an effort to dilute the study's impact on the reader. But this credible evidence that SOCE is safe and effective undermines the position of the SPLC that it has spread in courts and legislatures—that sexual orientation never changes, especially never changes through therapy, and that efforts to change it through therapy are harmful. The result has been depriving children of therapy—children who are victims of child abuse and other trauma that forced same-sex attraction on them. Another result has been discouraging adults who were such children from even trying therapy that addresses their childhood trauma.

59 SPLC, 2016, p. 4.
60 L. Haynes & C. LiMandri, JONAH case: The time for legal protection for sexual orientation change efforts is now, http://www.wnd.com/2016/02/sexual-orientation-change-efforts-under-attack/
61 Mustanski, Kuper, & Greene, 2014, 1:609-610.
62 SPLC, 2016, p. 37.

More evidence of the SPLC's practices of using "opinion-based smears and innuendos" as though they were educational and of violating governmental regulations comes from a 2017 Complaint against the SPLC to the IRS filed by the Federation for American Immigration Reform (FAIR). A press release published by FAIR that summarizes their complaint is titled, "FAIR Files Formal Exhaustive Complaint with the IRS: SPLC Violated Its Tax Exempt Status Repeatedly in the Last Election Cycle Alleges FAIR."[63]

The following quotes are from FAIR's press release summary of the complaint and address SPLC smear tactics:

> The SPLC used its tried and true formula of opinion-based smears and innuendos - tactics that it claims shield it from liability suits- to engage in blatant political activity masquerading as 'teaching tolerance.' The complaint reiterates that 'smear[ing] by association' is a 'primary technique of the SPLC'....
>
> According to IRS rules, organizations are not deemed educational, for instance, if their 'principal function is the mere presentation of unsupported opinion', if they 'fail [to] provide a factual foundation for the viewpoint or position being advocated' or they lack a 'full and fair exposition of the pertinent facts' which 'permit[s] an individual or the public to form an independent opinion or conclusion.'

These statements from the FAIR complaint also accurately describe the SPLC 2016 paper published on its website.

C. Summary

The purpose of this section was to highlight a few of the more egregious examples of false and misleading statements by the HRC, SPLC, and NCLR, their colleagues, and spokespersons.

Based on public statements on their websites, the NTFTE can now prove that these three organizations worked together, officially, in many of the campaigns described above. At the very least, it is clear they have cooperated with each other in other campaigns, spreading lies and providing misleading and false information to state liaisons (such as Garden State Equality) and actively promoted false stories of therapy torture, such as Brielle Goldani and NCLR spokesperson Samuel Brinton, while supporting persons who are providing misleading statements in front of state legislatures, such as the NCLR's spokesperson, Matthew Shurka, and Troy Stevenson, former Executive Director of Garden State Equality.

Additionally, SPLC also admits to working in cooperation with figures such as Wayne Besen, an active purveyor of tabloid-style journalism that regularly spins half-truths and lies of SOCE therapy on his website. In many cases, these three organizations (including Wayne Besen's Truth Wins Out) actively fundraise by promoting false and misleading statements about SOCE therapy. We believe this constitutes a clear violation of the Federal Trade Commission's consumer fraud laws.

We also want to acknowledge that while many additional inaccuracies have been told in front of state legislatures in the last five years by gay activists and other organizations working in cooperation with the HRC, SPLC, and NCLR, it would, however, be virtually impossible to document all of the fraudulent testimony and misleading statements. There are dozens, if not hundreds, of additional examples of fraudulent and misleading statements that exist in the public record of each of the twenty-five or so states that have introduced bills to ban SOCE therapy for minors.

IV. PETITIONERS' (LICENSED THERAPISTS AND CLIENTS) STATEMENT AND REQUEST

The Petitioners respectfully request that the Federal Trade Commission (FTC) investigate and put an end to the damaging, deceptive, and misleading hate campaigns of the SPLC, HRC and NCLR.

Pursuant to the FTC's mission to protect consumers from egregious, unfair, deceptive and fraudulent practices, in violation of Section 5 of the Federal Trade Commission Act, we request that the FTC take enforcement action to stop the deceptive practices promoted by the SPLC, HRC and NCLR, including advertising, marketing, and other business practices in all

63 FAIR press release, April 5, 2017, http://www.bizjournals.com/prnewswire/press_releases/2017/04/05/DC54600 ; Find the full complaint at http://www.fairus.org/DocServer/media/SPLC_Complaint.pdf

We also want to acknowledge that while many additional inaccuracies have been told in front of state legislatures in the last five years by gay activists and other organizations working in cooperation with the HRC, SPLC, and NCLR, it would, however, be virtually impossible to document all of the fraudulent testimony and misleading statements. There are dozens, if not hundreds, of additional examples of fraudulent and misleading statements that exist in the public record of each of the twenty-five or so states that have introduced bills to ban SOCE therapy for minors.

Despite the abundance of the historical and present day evidence of more than 125 years determining that traditional psychotherapy for unwanted SSA is effective in changing sexual attraction, behavior, and/or identity and is as effective as therapy for any other behavioral or emotional issue, Respondents' hate campaigns continue to mislead the public and pose serious health and safety risks to consumers, including the increased risk of death by suicide.

forms, including through their websites, brochures, videos, social media, fundraising e-mails, and other advertisements and promotional materials.

A. The Respondents Violations of Section 5 of the Federal Trade Commission

The Three Respondents' hate campaigns are intended to provide the public little or no choice in how to respond to unwanted same-sex attraction (SSA). The hate campaign propaganda is based on the false premise that being lesbian, gay, or bisexual is an unvarying and inborn characteristic of humanity.

There is no competent and reliable scientific evidence that has determined that SSA is fixed and not fluid. There is no scientific evidence that people are born gay. For those who are unhappy feeling SSA, a choice should be permitted. In fact, over the past 125 years there has been substantial valid and reliable scientific evidence that traditional therapy can work as well for unwanted SSA as it does for any other unwanted human behavior. Claims by respondents that therapies for SSA are ineffective are false and harmful to the public. Further, statistics show that both male and female homosexuals experience serious physical and emotional health risks as a result of their sexual behavior.

Despite the abundance of the historical and present day evidence of more than 125 years determining that traditional psychotherapy for unwanted SSA is effective in changing sexual attraction, behavior, and/or identity and is as effective as therapy for any other behavioral or emotional issue, Respondents' hate campaigns continue to mislead the public and pose serious health and safety risks to consumers, including the increased risk of death by suicide.[64]

Section 5 of the Federal Trade Commission ACT (FTC Act) prohibits unfair and deceptive acts and practices.[65] To determine whether business practices are deceptive, the FTC considers three elements.[66]

First, it considers whether there has been a representation, omission, or practice that is likely to mislead the consumer. Second, it examines the practice from the perspective of a consumer acting reasonably in the circumstances. Third, it asks whether the representation, omission or practice is a "material" one. Neither an intent to deceive nor actual consumer harm is required to find an act deceptive under the FTC Act.[67] This analysis focuses on the risk of consumer harm.

Both expressed misrepresentations and implied misrepresentations are violations of the FTC Act. If a claim is likely to be misleading without qualifying information, the qualifying information must be disclosed in a "clear and conspicuous" manner. Clear and conspicuous disclosure is required because the FTC focuses on the overall net impression of an advertisement, and if a disclosure is not seen or comprehended, it will not change the net impression consumers take from an advertisement. A disclosure can qualify or limit a claim to avoid a misleading impression; it cannot, however, cure a false claim.[68]

The FTC has also issued rules for specific areas relating to deceptive acts or practices, such as the use of testimonials in advertising.[69]

64 What Research Shows: NARTH's Response to the APA Claims on Homosexuality (Summary), p. 1, Family Watch International, http://www.familywatchinternational.org/fwi/NARTH_what_research_shows.pdf; The summary was of a full article, J. Phelan, N. Whitehead, & P.M. Sutton, 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, 2009, Journal of Human Sexuality, 1: 1-121. Available at https://media.wix.com/ugd/ec16e9_04d4fd5fb7e044289cc8e47dbaf13632.pdf
65 15 U.S.C. paragraph 45
66 FTC Policy Statement on Deception (1983), appended to Cliffdale Associates, Inc., 103 F.T.C. 110, 174 (1984), available at http://www.ftc.gov/bcp/policystmt/ad-decept.htm
67 See FTC vs Verity International, Ltd., 443 F3d 48, 63 (2nd Cir. 2006)
68 See FTC.com Disclosures: How to Make Effective Disclosures in Digital Advertising 5 (2013), available at: https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-staff-revises-online-advertising-disclosure-guidelines/130312dotcomdisclosures.pdf ("[A disclosure] cannot cure a false claim. If a disclosure provides information that contradicts a material claim, the disclosure will not be sufficient to prevent the ad from being deceptive."]
69 FTC, Guides Concerning the Use of Endorsements and Testimonials in Advertising, 16 CFR Part 255, available at https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-publishes-final-guides--governing-endorsements-testimonials/091005revised endorsementguides.pdf

B. The "Born Gay" Lie is a Deliberate Hoax Perpetrated by the Respondents

According to Kirk and Madsen, authors of *After the Ball: How America Will Conquer Its Fear and Hatred of Gays in the 90's*, the central role to be played by gay victimhood in the homosexual revolution, was that gay strategists would espouse the theory that homosexuals are "born that way"- in other words, that their sexual orientation is already determined at birth-whether or not there existed any scientific basis for such a claim. Individuals developing the hate campaigns of the HRC, SPLC, and NCLR, according to Kirk and Madsen, counsel their followers that they should portray themselves as victims of circumstances who "no more chose their sexual orientation than they did, say, their height, skin color, talents, or limitations." Revealingly, gay individuals such as Kirk and Madsen stress the need for homosexuals to stand behind the "Born Gay" theory--even though the authors themselves recognize its invalidity: "For all practical purposes, gays should be considered to have been born gay-even though sexual orientation, for most humans, seems to be the product of a complex interaction between innate predispositions and environmental factors during childhood and early adolescence."[70, 71]

The need to portray gays as victims is inseparably linked to the "Born Gay" hypothesis and needs to be addressed directly.

Jan Clausen, a former leader of New York's lesbian community (later expelled by her comrades for marrying a man) details how gay advocates developed this "born gay" fictive science as a tactic to influence public perceptions of sexual identity: "Fueled by the prestige of contemporary genetic science, the craze for biological explanations of all sorts of human behavior has given boost to 'born that way' theories of erotic attraction." Such pressure from "determinist" quarters, as well as "high profile campaigns for basic rights for gay men and lesbians" resulted in "obsessive media coverage of scientists' efforts to identify possible biological influences on sexuality," which, as the author herself acknowledges, were "commonly reported in oversimplified terms that foster notions of genetic determination not claimed by the researchers themselves." [72]

It bears stressing that as of the date of this publication, no genetic earmark distinguishing homosexuals from heterosexuals has been identified. So far as science has been able to discover, homosexuals and heterosexuals are genetically indistinguishable.[73] Moreover, as noted in

"People very much want to find simple answers... A gene for this, a gene for that...

Human behavior is much more complicated than that."

70 Madsen, H. & Mashall, K. (1991). After the Ball: How America Will Conquer Its Fear and Hatred of Gays in the 90's. Plume, P. 184.

71 Some of this text has been adapted from material published in: Light in the Closet: Torah, Homosexuality, and the Power to Change, Los Angeles: Red Heifer Press, 2d printing, 2009.

72 Jan Claussen, Apples & Oranges: My Journey Through Sexual Identity, Boston & New York: Houghton Mifflin (1999), p. 235.

73 Not one of the researchers commonly cited by gay activists has reported anything even close to proving the genetic nature of sexual orientation. Not one study claiming results favorable to the "gay gene" theory has ever been replicated under the scrutiny of rigorous experimental controls. The three most cited studies are not only seriously flawed, but the authors themselves have admitted that those studies should not be cited as proof of the gay gene theory. For example:

1. Dean Hamer claimed his study showed a statistically significant correlation between homosexual orientation and the genetic sequence of the top of the X chromosome. His study has been widely criticized for lacking a control group and for a statistical methodology that, according to charges by a former research colleague, was flawed by data selectively chosen to enhance Hamer's thesis. Even Dr. Hamer admitted that "These genes do not cause people to become homosexuals ...the biology of personality is much more complicated than that." Time, April 27, 1998, cited in Chad Thompson, The Homophobia Stops Here: Addressing the Ex Gay Perspective in Public Schools, Des Moines: In Queery (2004), p. 10.

2. In an attempt to show that sexuality is hard-wired into the brain via the hypothalamus, Simon LeVay examined the corpses of 19 homosexuals who died of AIDS complications and compared them with a group of 16 male and 6 female corpses he presumed were heterosexual. His debatable conclusion noted a difference in the size of a specific neuron group (INA H3). His results, too, could never be replicated. Shortly after the study's publication, an openly homosexual reporter correctly observed, "It turns out that LeVay doesn't know anything about the sexual orientation of his control group." Critiquing LeVay's claim that "he knows his control group are heterosexual because their brains are different from HIVer corpses," the same commentator jibes, "Sorry, doctor; this is circular logic. You can use the sample to prove the theory or vice versa, but not both at the same time." Michael Botkin, "Salt and Pepper," The Bay Area Reporter, September 6, 1991, pp. 21, 24, as quoted in Anton M. Marco, "Gay Marriage," <http://www.narth.com/ docs/marco.html>. LeVay himself is on record as stating: "The most common mistake people make in interpreting my work" is either that "homosexuality is genetic" or that it can prove "a genetic cause for being gay." Discover, March, 1994, as cited in Thompson, supra, p. 9. Hence, in spite of the torrents of propaganda about claimed differences ... versus "heterosexual" brains, no credible evidence has yet been found to support such claims. As Masters & Johnson conclude, "no serious scientist" would apply the "simple cause-effect relationship" of the genetic theory of homosexuality. Wm. Masters, Virginia Johnson, Robert Kolodny, Human Sexuality, Boston: Little Brown & Co. (2d ed. 1985), p. 411.

A 1993 scientific literature critique by Byne and Parsons in Archives of General Psychiatry reviewed more than 130 major studies on the subject and found no evidence favoring sexual orientation being either genetically or biologically determined

the highly respected British Medical Journal: "From an evolutionary perspective, genetically determined homosexuality would have become extinct long ago because of reduced reproduction."[74]

C. Evidence Against the Genetic/Biological Argument for Homosexuality

Genetics researcher Neil Risch noted in an August 1998 Newsweek article that the public has misunderstood behavioral genetics. "People very much want to find simple answers . . . A gene for this, a gene for that . . . Human behavior is much more complicated than that."[75]

Researchers Dar-Nimrod & Heine conclude:

> As there are no known complex human behaviors in which genetics render the actor unable to resist performing a behavior, we contend that genetic etiological accounts should not serve as the basis for moral evaluations . . . there are many other sources of influence at play... Furthermore, the amount of influence that genes have on behaviors is considerably smaller than one might think.[76]

The three rules of behavioral genetics by genetics researcher Erik Turkheimer (University of Virginia) are:[77]

1. All human behavioral traits are heritable.

2. The effect of being raised in the same family is smaller than the effect of genes.

3. A substantial portion of the variation in complex human behavioral traits is not accounted for by the effects of genes or families.

A 1993 scientific literature critique by Byne and Parsons in Archives of General Psychiatry reviewed more than 130 major studies on the subject and found no evidence favoring sexual orientation being either genetically or biologically determined.[78]

In 1987, sociologist Lee Ellis proposed the Maternal Stress Theory, which argues that maternal neurohormones functioned in determining the sexual orientation of a fetus.[79] In January 2012, psychology professor Stanton Jones posted an essay: "Sexual orientation and reason: On the implications of false beliefs about homosexuality." Jones details three primary theories in the debate regarding biological origins of same-sex sexual orientation: Maternal stress, fraternal birth order, and genetics. In reviewing Ellis' work on Maternal Stress Theory, Jones found strong selection bias in Ellis' study in that Ellis surveyed mothers of gay sons while the mothers were being instructed about maternal stress theory itself. [80]

In 2003, Anthony Bogaert of Canada's Brock University published a survey study showing that fraternal birth order of men, specifically the number of older brothers born to the same mother, correlated to increased chances of homosexual orientation. The theoretical explanation was that the mother's immune system became sensitized to male-derived proteins.[81]

1. Recruitment bias in the study led to non-representative sampling.
2. Canadian Psychiatrist Joseph Berger, M.D., a Distinguished Fellow with the American Psychiatric Association, said: "It [Bogert's study] is rubbish. It should never have been published. I suspect it was not peer-reviewed properly or was reviewed by someone

74 Miron Baron, "Genetic Linkage and Male Homosexual Orientation," British Medical Journal, Vol. 307 (Aug. 7, 1993), p. 337, cited in Peter Sprigg and Timothy Dailey (eds.), Getting It Straight: What The Research Shows about Homosexuality, Family Research Council, Washington, D.C. (2004), p. 13.

75 Leland, J. & M. Miller, "'Convert'?" Newsweek, August 17, 1998, p. 49.

76 Dar-Nimrod, I., & Heine, S.J. (2011b). Some thoughts on essence placeholders, interactionism, and heritability: Reply to Haslam (2011) and Turkheimer (2011). Psychological Bulletin, 137(5), 829-833.

77 Current Directions in Psychological Science, Vol. 9, N. 5, Oct. 2000, 160-164.

78 Byne, W. & Parsons, B. (1993), "Human sexual orientation: the biologic theories reappraised." Archives of General Psychiatry, 50, p. 229-239.

79 L. Ellis and A. Ames (1987), "Neurohormonal functioning and sexual orientation: A theory of homosexuality-heterosexuality," Psychological Bulletin, 101, 233-238.

80 Stanton L. Jones (January, 2012), "Sexual orientation and reason: On the implications of false beliefs about homosexuality," digitally published at www.christianethics.org.

81 A. F. Bogaert (2003), "Number of older brothers and sexual orientation: New tests and the attraction/behavior distinction in two national probability samples," Journal of Personality and Social Psychology, 84 (3), 644-652.

so biased and ignorant that they were unable to see the huge flaws and [are] essentially ignorant of the literature."[82]

3. The media was quick to carry Bogaert's claims but not the criticisms. Dr. Stanton Jones noted in his review:
   a. Bogaert [then] analyzed two smaller nationally representative samples, finding an exceptionally weak 'older brother' effect only for same-sex attraction (and no effect for same-sex behavior)."[83]
   b. Bogaert then assessed "an independent . . . and representative sample eight times the size those of his previous studies, in which he found that the older brother effect had disappeared."[84]
   c. A study of two million Danish subjects[85] and another of 10,000 American adolescents also identified no "older brother" effect.[86]

The genetic hypothesis of same-sex sexual orientation has long held sway in the media, and twin studies helped propel this. Michael Bailey and colleagues conducted numerous studies in an attempt to show a statistically significant concordance of homosexuality in identical twins. Since identical twins share the same gene pool, the existence of a "gay gene" should have produced a near 100% rate of concordance. However, the highest percentage ever tabulated was just over 50%. When Bailey tried to replicate his findings with an Australian population of twins, his new study showed homosexuality concurring in less than half the number claimed in his original study. Dr. Neil Whitehead has extensively analyzed these studies and debunked the genetic theories.[87]

Prof. Jones wrote that in a 1991 Archives of General Psychiatry study, J. Bailey claimed that the concordance rate for homosexuality was 52 percent in identical male twin pairs.[88] Bailey had second thoughts about how his study subjects were recruited through advertisements in Chicago's gay community (multiple biases). He next examined samples from the Australian Twin Registry, producing an identical male twin homosexual orientation concordance rate of 20 percent with simple descriptive matching at 11 percent. Bailey reported that the genetic contribution to homosexual orientation failed to show statistical significance, but the media did not tune in.[89]

A 2010 study of the Swedish Twin Registry found only 9.8 percent of identical male twin pairs matching for homosexual orientation.[90]

Dr. Francis Collins, who was the director of the Human Genome Project at the National Institutes for Health stated: "... the likelihood that the identical twin of a homosexual male will also be gay is about 20% (compared with 2-4 percent of males in the general population), indicating that sexual orientation is genetically influenced but not hardwired by DNA, and that whatever genes are involved represent predispositions, not predeterminations."[91]

Per Dr. Neil Whitehead's analysis: "... if one identical twin—male or female—has SSA, the chances are only about 10 percent that the co-twin also has it. In other words, identical twins usually differ for SSA."[92]

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82 http://www.narth.com/docs/bogaert.html

83 A. F. Bogaert (2003), "Number of older brothers and sexual orientation: New tests and the attraction/behavior distinction in two national probability samples," Journal of Personality and Social Psychology, 84 (3), 644-652.

84 A. F. Bogaert (2010), "Physical development and sexual orientation in men and women: An analysis of NATSAL-2000," Archives of Sexual Behavior, 39, 110-116.

85 M. Frisch, & A. Hviid (2006), "Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes, Archives of Sexual Behavior 35(5), 533-547.

86 A. M. Francis (2008), "Family and sexual orientation: The family-demographic correlates of homosexuality in men and women," Journal of Sex Research, 45, 371-377.

87 See Whitehead, N. www.mygenes.co.nz.

88 J. M. Bailey & R. C. Pillard, "A genetic study of male sexual orientation," 1991, Archives of General Psychiatry, 48, 1081-1096.

89 J. M. Bailey, M.P. Dunne, N. G. Martin, "Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample," 2000, Journal of Personality and Social Psychology, 78 (3), 524-536.

90 N. Långström, Q. Rahman, E. Carlstrom, & P. Lichtenstein,, "Genetic and environmental effects on same-sex sexual behavior: A population study of twins in Sweden," 2010, Archives of Sexual Behavior, 39, 75-80.

91 Byrd, A.D, "Homosexuality Is Not Hardwired," Concludes Dr. Francis S. Collins, Head Of The Human Genome Project. NARTH.com. April 4, 2007.

92 http://www.narth.com/docs/isminor.html.

Notwithstanding the flaws in "gay gene studies," and thanks to the constant bombardment of misinformation and disinformation by the media and the hoax perpetrated by SPLC, HRC and NCLR, the myth of a "gay gene" has seeped into the public consciousness.

Dr. Eric Turkheimer, psychologist and behavioral genetics researcher, indicates there are two reasons why identical twins raised in the same family do not have identical outcomes. One is measurement error. The other: "...is the self-determinative ability of humans to chart a course for their own lives, . . . in a phrase, is free will." [93]

In a review by Kelly Servick in 2014, it was reported that Bailey and Sanders presented another X-linked "gay gene" study. Scientists were not impressed because "genetic linkage" was used for DNA analysis rather than the current "genome-wide association" (GWA), and the researchers took an awfully long time to get published. They didn't show underlying/causative genes, and Sanders reportedly admitted the Xq28 linkage was not statistically significant. (Neil Risch's 1999 study disproving Xq28 was cited).[94]

D. So how much of sexual orientation is genetic versus environmental?

Eric Turkheimer, an expert in the field, warns that heritability statistics are tricky due to difficulty in clearly seeing and assessing environmental factors, which he feels contribute strongly to development.[95]

Elsewhere, Turkheimer states: "... the amount of influence that genes have on behaviors is considerably smaller than one might think."[96] He insists: "... genetic essentialists were wrong about gay genes and similar nonsense."[97]

Epigenetics analyzes the interaction of genes and environment. There is a life-long interplay between our genetic blueprints and our chains of choices and their consequences. For example, the more weight one gains, the more likely diabetes manifests. But even in the genetically disposed, diabetes can often be avoided or reversed by the right choices over time. Epigenetics changes constantly in response to environment and the choices we make. Looking for causation there is a recipe for misunderstanding behavior. Again, genes determine predispositions, not destiny. Heritability is not inevitability.

A UCLA team reported at the October 2015 American Society of Human Genetics conference identifying epigenetic markers with which they could predict with nearly 70% accuracy if men were homosexual. The media reported approvingly, and the scientists at the conference tore it apart for poor method and poor validity of results. Dr. John Greally (Albert Einstein College of Medicine) stated: "We can no longer allow poor epigenetics studies to be given credibility if this field is to survive . . . The problems in the field are systematic."[98]

Notwithstanding the flaws in "gay gene studies," and thanks to the constant bombardment of misinformation and disinformation by the media and the hoax perpetrated by SPLC, HRC and NCLR, the myth of a "gay gene" has seeped into the public consciousness. For example, after the 1993 publication of Dr. Hamer's study, the New York Times headlined: "Report Suggests Homosexuality is Linked to Genes," while the Wall Street Journal trumpeted, "Research Points Toward a 'Gay' Gene." Two later headlines in the New York Times illustrate the ongoing effort to keep the theory alive: "Study Reveals New Difference between the Sexes" and "For Gay Men, Different Scent of Attraction."[99]

Prof. Paul McHugh of Johns Hopkins University said: "Unlike the traits of race and sex, and again despite popular beliefs to the contrary, no replicated scientific study supports the view that sexual orientation is determined at birth."[100]

93 Turkheimer, E. (2011). Genetics and human agency: Comment on Dar-Nimrod and Heine (2011). Psychological Bulletin, 137(5), p. 826.

94 K. Servick, Study of gay brothers may confirm X chromosome link to homosexuality, Nov. 17, 2014, http://news.sciencemag.org/biology/2014/11/study-gay-brothers-may-confirm-x-chromosome-link-homosexuality.

95 E. Turkheimer (2000), "Three laws of behavior genetics and what they mean," Current Directions in Psychological Science, 9, 160-164; quotes p. 162.

96 Dar-Nimrod, I., & Heine, S.J. (2011b). Some thoughts on essence placeholders, interactionism, and heritability: Reply to Haslam (2011) and Turkheimer (2011). Psychological Bulletin, 137(5), 829-833, (quote on p. 831).

97 Turkheimer, E. (2011). Genetics and human agency: Comment on Dar-Nimrod and Heine (2011). Psychological Bulletin, 137(5), 825-828.

98 No, Scientists Have Not Found the 'Gay Gene'. theatlantic.com, Oct. 10, 2015.

99 New York Times. March 17, 2005, p. A25; and New York Times, May 10, 2005, p. 1.

100 Dr. Paul McHugh's amicus brief to the SCOTUS on Obergefell v. Hodges.

The American Psychological Association has reviewed the research literature on origins of same-sex sexuality in the *APA Handbook of Sexuality and Psychology (APA Handbook)*.[101] There is no question that the APA considers its *Handbook* to be authoritative. In its "Series Preface," the *APA Handbook* on Sexuality and Psychology states:

With the imprimatur of the largest scientific and professional organization representing psychology in the United States and the largest association of psychologists in the world, and with content edited and authored by some of its most respected members, the *APA Handbooks in Psychology* series will be the indispensable and authoritative reference resource to turn to for researchers, instructors, practitioners, and field leaders alike.[102]

The American Psychological Association (APA) could not confer any higher authority on the *APA Handbook of Sexuality and Psychology* than it does, bestowing its "imprimatur" and calling it "authoritative." In addition, Dr. Lisa Diamond, a self-avowed lesbian, is co-editor-in-chief of the *Handbook*, and she authors and co-authors chapters in it. She qualifies as one of the APA's "most respected members."

Regarding whether there is a "gay gene," Rosario and Scrimshaw say in the *APA Handbook*, "[W]e are far from identifying potential genes that may explain not just male homosexuality but also female homosexuality."[103] The authors of the *APA Handbook* still hold that as-yet-unidentified genes contribute toward same-sex attraction in some way.

Diamond and colleagues said in 2016, "To provide a basis of comparison, it is helpful to note that higher estimates of heritability (ranging from .4 [40%] to .6 [60%]) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction."[104] One may well note that these conditions (with the exception generally for lower back pain) are also widely considered to be changeable for some through psychological intervention and without harm.[105] Estimates of heritability for same-sex attraction are 40% to 50% in the *APA Handbook*[106] but 32% in more recent publications of Diamond and colleagues.[107]

With respect to the role of epigenetics, Diamond and Rosky point out, "In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being "born gay," along with the notion of being "born" with any complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded" (emphasis added).[108]

Regarding the fraternal birth order hypothesis, Diamond and Rosky conclude: "Prenatal hormones potentially contribute to same-sex sexuality in some individuals but do not determine it."[109]

Historically, some have conceded that some same-sex sexuality is not biologically determined while maintaining that some is. Kleinplatz and Diamond conclude: "The inconvenient reality... is that social behaviors are always jointly determined by 'a range of constitutional propensities interacting with a range of facultative opportunities' ... rendering the entire constitution-facultative distinction (and, of course, its implied nature-nurture distinction) overly simplistic."[110]

Diamond and Rosky explain: "Even if sexual orientation were wholly determined by genes or by perinatal hormones, it would not mean that it was immutable, given that immutable means unchangeable. Although the status of a trait as biologically determined is often inflated with its capacity to change over the life course, these are not synonymous constructs."[111]

In summary, the scientific literature *does not* (emphasis added) support sexual orientation being genetically or biologically determined.

E. What Else Contributes to Same-Sex Attractions and Gender Dysphoria?

The 2008 American Psychological Association's brochure (and their current website, April 2017) states:

> 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; most people experience little or no sense of choice about their sexual orientation.[112]

Dr. Jeffrey Satinover says of homosexuality: "It is most often a deeply-embedded condition that develops over many years, beginning long before the development of moral and self-awareness, and is genuinely experienced by the individual as though it was never absent in one form or another. It is, in other words, similar to most human characteristics, and shares with them the typical possibilities for, and difficulties in, achieving sustained change."[113]

Dr. Nicholas Cummings, Ph.D., Sc.D. (past APA president, 20 years Chief of Mental Health of Kaiser-Permanente HMO, practiced in San Francisco) oversaw the treatment of 18,000 gay and lesbian clients in their system over the years with conflicts over their homosexuality and personally treated 2000.[114] He concluded:

> There are many kinds of homosexuality: "There are as many kinds of homosexuals as heterosexuals. Homosexuality is not a unitary experience. [Some gays were quite promiscuous in response to a chaotic upbringing; some had wonderful families. Some were very conforming with traditional gender roles and others were not."]. No single cause for all homosexuality: "Dogmatism about causes is unwarranted . . . clinical experience contradicts efforts to reduce homosexuality to one set of factors."[115]

In 2001, a study published by Tomeo, et al. found that 942 nonclinical adult participants: homosexual molestation was reported by 46% of the homosexual men, but 7% of the heterosexual men; and 22% of lesbian women, but only 1% of heterosexual women.[116]

In the *APA Handbook of Sexuality and Psychology*, Mustanski, Kuper, and Greene confirm there is excellent research evidence for "associative or potentially causal links" between childhood sexual abuse and ever having same-sex partners, especially for some men."[117] They said, "The largest reviews of the literature in this area indicated that MSM [men who have sex with men] report rates of childhood sexual abuse that are approximately three times higher than that of the general male population (Purcell, Malow, Dolezal, & Carballo-Dieguez, 2004)."[118]

Mustanski and colleagues continue in the *APA Handbook*: "One of the most methodologically rigorous studies in this area used a prospective longitudinal case-control design that involved following abused and matched nonabused children into adulthood 30 years later. It

Diamond and Rosky explain: "Even if sexual orientation were wholly determined by genes or by perinatal hormones, it would not mean that it was immutable, given that immutable means unchangeable. Although the status of a trait as biologically determined is often inflated with its capacity to change over the life course, these are not synonymous constructs."

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101 D. Tolman & L. Diamond, Co-Editors-in-Chief, 2014, APA Handbook of Sexuality and Psychology (2 volumes). Washington D.C.: American Psychological Association.
102 Ibid., 1:xvi.
103 Rosario & Schrimshaw, 2014, 1:579, in APA Handbook.
104 Diamond & Rosky, 2016, p. 4.
105 As an example, for smoking, the APA developed and offers a psychological intervention in the form of a free mobile app, which lists evidence-based smoking-cessation interventions and other resources (APA, 2016, p. 76).
106 Rosario & Scrimshaw, 2014, 1:579. in APA Handbook.
107 Diamond & Rosky, 2016, p. 2; taken from Bailey et al including Diamond, 2016, p. 76.
108 Ibid.
109 Ibid., 2016, p. 4.
110 Kleinplatz & Diamond, 2014, 1:257, in APA Handbook.
111 Ibid.
112 http://www.apa.org/topics/sexuality/orientation.aspx
113 Satinover, Jeffrey, MD, "Dr. Jeffrey Satinover, M.D. Testifies in Mass. in Defense of the Family," www.Satinover.com, 4/29/2004.
114 Cummings, N. (July 30, 2013). Sexual reorientation therapy not unethical: Column; Southern Poverty Law Center wrongly fighting against patients' right to choose. http://www.usatoday.com/story/opinion/2013/07/30/sexual-reorientation-therapy-not-unethical-column/2601159/
115 Warren Throckmorton, PhD, "Homosexuality and Psychotherapy: An Interview with Nicholas Cummings," February 19, 2007.
116 Tomeo, ME, "Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons." Arch Sex Behav. 2001 Oct;30(5):535-41.
117 Mustanski, Kuper, & Greene, 2014, 1:609-610, in APA Handbook.
118 Ibid.

found that men with documented histories of childhood sexual abuse had 6.75 times greater odds than controls of reporting ever having same-sex sexual partners (H. W. Wilson & Widom, 2010...The effect in women was smaller (odds ratio = 2.11) and a statistical trend (p = .09)."[119]

Not only sexual trauma, but psychoanalytic factors also contribute to same-sex attractions, according to the *APA Handbook of Sexuality and Psychology* upon which the APA confers its imprimatur and which it declares "authoritative." In the *Handbook*, Rosario and Schrimshaw say: "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors....A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful."[120]

There is excellent research showing loss of living with a biological parent, as through death, divorce, end of parent co-habitation, or unknown paternity, is potentially causally linked to same-sex attraction, relationships, and self-label identity. Evidence comes from three large, prospective, longitudinal, population-based studies.[121]

In the most stunning of these, a study of an entire population cohort of 2 million Danes found that loss of a biological parent—especially the parent of the same-sex as the child, especially during the first six years of life, and for girls the death of the mother during adolescence—was potentially causally related to entering a same-sex marriage rather then an opposite-sex marriage. The effects were stronger for boys than for girls.[122] The study found no evidence of the FBO effect. These findings give evidence that potentially causal social environmental factors have effects in the earliest years of childhood development. Hence, evidence for an early origin for same-sex sexuality does not in itself argue for a biological origin.

In America, similar evidence was found by studies that used the data set of the National Longitudinal Study of Adolescent to Adult Health, or Ad Health. [123] In one of these studies, Francis[124] looked at the first two waves conducted with participants at ages 16 and 17. He found that growing up without a biological mother increased the likelihood of identifying as non heterosexual by 9.5 percentage points for girls and by 4.5 percentage points for boys. Thus, mother absence was related to increased non-heterosexual identity, especially in daughters. A boy growing up without either biological parent increased the likelihood of same-sex attraction, behavior, and sexual orientation identity. The study failed to find evidence for the FBO effect.

But Francis did not find a relationship specifically between absence of the father and same-sex sexuality for a son during the first two waves of the Ad Health study. Udry and Chantala[125] looked at the first three waves, obtaining data at ages 16, 17, and 18 through 24, from the Ad Health data set. Unlike Francis, Udry and Chantala measured sexual attraction on two separate scales for degree of same-sex attraction and degree of opposite-sex attraction. They found that among boys who had strong same-sex interest, 90% had absent fathers, a very strong affect. The stronger the degree of same-sex attraction, the greater the likelihood of father absence, delinquency, and suicidal thoughts. As opposite sex attraction also rose, that relationship completely disappeared. [126] Where the biological father was present, boys were likely to experience opposite-sex attraction, possibly alongside same-sex attraction. Girls who grew up with their father absent evidenced high sex interest directed at either sex.[127] Thus, father absence was related to same-sex attraction, especially in boys.

There is evidence that transgender identity also may not be a normal sexual variation. The APA Handbook says the origin of transgender identity is "most likely the result of a complex interaction between biological and environmental factors..."

The falsehoods that the SPLC, HRC, and NCLR promote lead the public and some mental health professionals to assume that all individuals who experience any same-sex attraction are really exclusively homosexual and would be happier leaving their heterosexual marriage and breaking up their family to go have same-sex relationships.

119 Ibid., p. 609.
120 Rosario & Shrimshaw, 2014, 1:583, in APA Handbook.
121 Frisch, M. and Hviid, A., Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes, Archives of Sexual Behavior, 2006,35:533-547; Francis, A. M., Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 2008, 45 (4):371-377, DOI:10.1080/00224490802398357; J.R. Udry & K. Chantala, Risk factors differ according to same- sex and opposite-sex interest. Journal of Biosocial Science, 2005, 37:481–497, http://dx.doi.org/10.1017/S0021932004006765.
122 Frisch & Hviid, 2006, p. 545.
123 K.M. Harris, C.T. Halpern, E. Whitsel, J. Hussey, J. Tabor, P. Entzel, and J.R. Udry, The National Longitudinal Study of Adolescent to Adult Health: Research Design, 2009, http://www.cpc.unc.edu/projects/addhealth/design
124 A. M. Francis, Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 2008, 45 (4):371-377, DOI:10.1080/00224490802398357
125 Udry, & Chantala, 2005.
126 Ibid., p. 487.
127 Ibid., p. 491.

Regarding childhood gender dysphoria or distress, the *APA Handbook* has some important things to say. There is evidence that transgender identity also may not be a normal sexual variation. The *APA Handbook* says the origin of transgender identity is "most likely the result of a complex interaction between biological and environmental factors... Research on the influence of family of origin dynamics has found some support for separation anxiety among gender-nonconforming boys and psychopathology among mothers."[128]

Further, Bockting says in the *APA Handbook*: "Premature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role, such as registering a birth-assigned boy in school as a girl) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development." If there is early social transition, "the stress associated with possible reversal of this decision has been shown to be substantial...."[129]

The American Psychological Association, in its *Handbook*,[130] and the American Psychiatric Association in its Diagnostic and Statistical Manual[131] say there are three approaches to treatment: attempts to lessen the dysphoria and nonconformity, attempts to get the environment—family, school, and community—to fully accept the child's gender-variant identity, and the wait-and-see approach. The *APA Handbook* warns that the full acceptance approach "runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist."

F. Living Things Change and So Can Same-Sex Attraction: Change is Well Documented in Adolescents and Adults without Intervention

Conventional wisdom that the *APA Handbook* says it is not true is that same-sex attraction never changes. The *APA Handbook* states: "[R]esearch on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or [orientation] identities over time."[132] "Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation."[133] "Over the course of life, individuals experience the following:...changes or fluctuations in sexual attractions, behaviors, and romantic partnerships."[134]

The *APA Handbook* states: "[I]n all studies, heterosexual identified individuals show greater stability than non heterosexual..."[135] That is, change is greater for same-sex sexuality than for heterosexuality.

Many individuals who seek therapy with the goal of making a significant and meaningful shift in their sexual attraction already begin with some degree of opposite-sex attraction alongside same-sex attraction, and the combination generally increases potential for change. In the *APA Handbook*, Dr. Diamond states: "Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally.[136]

128 Bockting, W. (2014). Chapter 24: Transgender Identity Development. In D. Tolman, & L. Diamond, Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology (2 volumes), 2014, Washington D.C.: American Psychological Association.
129 Ibid., 1:744.
130 Ibid, 1:750-751.
131 American Psychiatric Association, 2013, DSM-5, p. 455.
132 L. Diamond, "Chapter 20: Gender and same-sex sexuality," in D. Tolman & L. Diamond, Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, 2014, Washington D.C.: American Psychological Association, 1:636.
133 M. Rosario & E. Schrimshaw. "Ch. 18: Theories and etiologies of sexual orientation," in D. Tolman & L. Diamond, Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, Washington D.C.: American Psychological Association, 1:562).
134 B. Mustaky, L. Kuper,and G. Geene, "Chapter 19: Development of sexual orientation and identity" in D. Tolman, L.Diamond, Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, Washington D.C.: American Psychological Association, 2014, 1:619.
135 Diamond, 2014, 1:636.
136 Diamond, 2014, 1:633.

Plentiful evidence (multiple large, prospective, longitudinal, representative sample and cohort studies) makes clear that both-sex attracted individuals (including bisexual and mostly heterosexual individuals) account for most same-sex sexuality, and both-sex attracted individuals experience the most change in attraction, behavior, and identity over time.[137]

Kleinplatz and Diamond say: "Historically such individuals [mostly heterosexual] have been treated with skepticism and suspicion by laypeople and scientists alike. They have been viewed as either closeted lesbian, gay, or bisexual individuals (who cling to a mostly heterosexual label to avoid the stigma associated with same-sex sexuality) or as confused or questioning 'heteroflexibles.'"[138]

Kleinplatz and Diamond urge that "it is critically important for clinicians not to assume that any experience of same-sex desire or behavior is a sign of latent homosexuality and instead to allow individuals to determine for themselves the role of same-sex sexuality in their lives and identity."[139]

The falsehoods that the SPLC, HRC, and NCLR promote lead the public and some mental health professionals to assume that all individuals who experience any same-sex attraction are really exclusively homosexual and would be happier leaving their heterosexual marriage and breaking up their family to go have same-sex relationships. An anecdotal illustration of the harm comes from the experience of a man whose therapist told him his sexual attraction could not change, and he would be happier leaving his wife and daughter to have gay relationships. In despair, not relief, he left his marriage and family, and for nine years he had gay relationships, living a life he did not want to live. At the end, he decided to get help to change his sexual attraction, and he married a woman. But he grieves the years he and his daughter lost that he was not living with her and raising her full time, a loss that can never be made up to them. [140]

Yes, they should. Some non exclusively same-sex attracted individuals want to protect their heterosexual relationship and family by stopping periodic same-sex behavior. Should they be able to get that help? Yes, they should, Some non exclusively same-sex attracted minors or young adults aspire to be able to be in an opposite sex relationship and to procreate children with their partner and raise them together, as many people aspire to do, but they may need help to change periodic or a small amount of same-sex attraction. The SPLC, HRC, and NCLR tell them they can never change and try to make therapy to help them be illegal.

Also, both the American Psychiatric Association[141] and the American Psychological Association[142] recognize childhood transgender identity fluctuates. As many as 75% to 98% of gender-confused boys and as many as 75% to 88% of gender confused girls will eventually accept their chromosomal sex by adolescence or adulthood if allowed to do so.

Change is the norm for sexual orientation and childhood gender dysphoria. Therapy that is open to exploring an individual's potential for a shift in sexual attraction or gender identity is better aligned with the norm of change and direction of change for sexual orientation and childhood gender dysphoria than is gay-affirmative or transgender-affirmative therapy.

Adolescents who experience any same-sex attraction, behavior, or identity self-label should not be led to interpret these as meaning they have a stable sexual orientation trait. Researchers nowadays do not even try to measure homosexuality as a stable or coherent trait. Instead, they often measure sexual orientation by one or more of three separate components: sexual attraction, behavior, or self-label identity. The *APA Handbook* says these do not necessarily match within the same individual.[143]

137 R. Savin-Williams, K. Joyner, & R. Rieger, Prevalence and stability of self-reported sexual orientation identity during young adulthood. Archives of Sexual Behavior, 2012, 41:104, 106, 109; Diamond & Rosky, 2016, pp. 6-9; see Table 1 on p. 7; Diamond, 2014, 1:633-635, in APA Handbook.
138 Kleinplatz & Diamond, 1:256, in APA Handbook.
139 Ibid., 1:257.
140 Personal communication between this man and one of the authors of this document. This man was not a client of anyone associated with this document.
141 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Arlington, VA: American Psychiatric Association, 2013, calculations from p. 455 yield the 98% and 88% figures.
142 W. Bockting, "Chapter 24: Transgender Identity Development," in D.Tolman & L. Diamond, Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, Washington D.C.: American Psychological Association, 1:744 gives the 75% figure.
143 Rosario & Schrimshaw,1:558-559; Diamond, 2014, 1:634; both in APA Handbook.

Diamond and Rosky concluded: "Several... studies have now been completed and they unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals." Across several large, population-based, prospective, longitudinal studies, among same-sex attracted individuals who changed, 50 to 100% changed to exclusive heterosexuality.

Udry and Chantala, examining the data from the first two waves, found 89% of exclusively same-sex attracted boys experienced change in sexual identity in just one year from age 16 to age 17. After one year's time, only 11% remained identified as exclusively same-sex attracted. The majority, 54%, migrated toward or to exclusive heterosexuality, with 48% exclusively opposite-sex attracted and 6% newly attracted to both sexes. These results show that nearly half of adolescent boys changed from exclusive homosexual attraction to exclusive heterosexual attraction in just one year.

For example, heterosexual minors who had same-sex attraction and behavior forced upon them by childhood molestation could have bisexual attraction, homosexual behavior, and heterosexual identity, if there is a sense that the same-sex sexuality does not represent the authentic self.

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Opponents of SOCE often claim that sexual attraction can never change from exclusively same-sex attraction to exclusively opposite-sex attraction. But that is not true. The University of Chicago 1994 (US) National Health and Social Life Survey (UHSLS) conducted by Laumann and colleagues reported that "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."[146] This study continues to be highly regarded and has not ceased to be cited by leading researchers to this day, as exemplified by numerous citations in the *APA Handbook*.[147]

There is yet more excellent evidence of complete change from exclusive same-sex attraction to exclusive opposite-sex attraction in adolescents. The National Longitudinal Study of Adolescent to Adult Health (Ad Health) is also highly regarded and is reviewed in the *APA Handbook*. It has now gone through five waves of data collection on a large, nationally representative sample. Udry and Chantala, examining the data from the first two waves, found 89% of exclusively same-sex attracted boys experienced change in sexual identity in just one year from age 16 to age 17. After one year's time, only 11% remained identified as exclusively same-sex attracted. The majority, 54%, migrated toward or to exclusive heterosexuality, with 48% exclusively opposite-sex attracted and 6% newly attracted to both sexes. These results show that nearly half of adolescent boys changed from exclusive homosexual attraction to exclusive heterosexual attraction in just one year. For 35% of the boys, same-sex attraction dropped out, but heterosexual attraction had not developed. They became neither-sex attracted. Boys who were neither-sex attracted in early adolescence went on to develop attraction to women in the Ad Health study as Savin-Williams and Ream continued to follow them.[148]

In support of findings of Savin-William and Ream, it may be noted here that similar results were found in the Growing Up Today Study (GUTS) in 2013. This study is a large, prospective, longitudinal cohort study of the children of women participating in the Nurses' Health Study II. The researchers, Ott and colleagues, documented the plasticity of same-sex sexuality of youth beginning at ages 9 through 14 and following up every two years thereafter.[149] They found that youth who were unsure or uncertain of their sexual identity predominantly migrated to an exclusive heterosexual identity.[150]

Savin-Williams and Ream (2007), commenting on the findings of the first three waves of the Ad Health study, said that, overall, the majority of shifts in sexual behavior were toward heterosexuality.[151] "Participants indicating non heterosexuality in Wave 1 were often not the same individuals who indicated non heterosexuality one and five years later.[152] "All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time."[153]

144 Diamond & Rosky, 2016, p. 6.
145 Ibid., p. 7, Table 1.
146 E. O. Laumann, J. H. Gagnon, R. T. Michael, & S. Michaels, The Social Orgnaization of Sexuality: Sexual Practices in the United States, Chicago: University of Chicago Press, 1994, p. 296.
147 Examples in APA Handbook, 2014: Diamond 1:645; Rosario & Schrimshaw, 1:557, 558-559, 564.
148 Rosario & Schrimshaw, 2014, 1:256, in APA Handbook, regarding Savin-Williams & Ream, 2007.
149 M. Ott, D. Wypij, H. Corliss, M. Rosario, S. Reisner, A. Gordon, S. Austiln, Repeated changes in reported sexual orientation identity linked to substance use behaviors in youth, Journal of Adolescent Health, 2013 52(4): 465-472. http://dx.doi.org/10.1016/j.jadohealth.2012.08.004.
150 Rosario & Scrimshaw, 2014, 1:562, in APA Handbook.
151 Savin-Williams and Ream, 2007, p. 386.
152 Ibid., p. 393.
153 Ibid., p. 389.

Reflecting on the first four waves of the Ad Health study, Savin-Williams and Joyner in 2014 observed that: "approximately 80% of adolescent boys and half of adolescent girls who expressed either partial or exclusive same-sex romantic attraction at Wave I 'turned' hetero-sexual (opposite-sex attraction or exclusively heterosexual identity) as young adults."[154]

There has been some debate as to whether some of the adolescent participants that Savin-William and Ream studied in the first three waves acted as "jokesters" in their responses, resulting in the high rates of same-sex attracted adolescents becoming heterosexual.[155] However, the authors had noted that their findings are consistent with those of other highly regarded studies, including that of Laumann and colleagues. The latter, one may note, obtained their findings from retrospective reports by adults aged 18 to 59,[156] not from 16 or 17 year olds. Savin-Williams and colleagues had highlighted that Laumann et al. "expressed doubt about the extent to which non heterosexual sexual categories, behaviors, and attractions remained stable over time.... Yet, researchers readily acknowledge the existence of such sexual groups ("gay youth") with little evidence that these individuals will be in the same group a month, a year, or a decade henceforth."[157]

It was important that students' sexual confusion is not entrenched by the born-that-way-and-can't-change rhetoric of the SPLC, HRC, and NCLR. The norm is that most will experience change if allowed to. It is possible, however, that some may need help from therapy in the process.

Prof. Paul McHugh said: "... researchers have found that all three of the most frequently mentioned dimensions of sexual orientation – attraction, behavior, and identity – are subject to change over time."[158]

From Columbia University Press: "At clinical conferences one often hears . . . that homosexuality is fixed and unmodifiable. Neither assertion is true...The assertion that homosexuality is genetic is so reductionist that it must be dismissed out of hand as a general principle of psychology."[159]

Dr. Dean Hammer said: "Women tend to be more sexually fluid. We've interviewed lesbians who have always identified as lesbian but who fantasize about men."[160]

Dr. Lisa Diamond determined from her research: "Sexuality identity is far from fixed in women who aren't exclusively heterosexual."[161]

Dr. Lisa Diamond, co-editor in chief of the *APA Handbook of Sexuality and Psychology*, an avowed lesbian, and a political activist, is adamantly on a campaign to get political activists such as those at the SPLC, HRC, and NCLR, to stop perpetrating the harmful claim that sexual orientation does not change, like skin color. For nearly a decade, she has not backed down on her mission, yet the SPLC, HRC, and NCLR have knowingly continued to push their false and misleading claims.

The following are some examples of her statements that such claims are false, misleading, and harmful.

Dr. Diamond reported on her 10-year longitudinal study of non-heterosexual women in her book, *Sexual Fluidity: Understanding Women's Love and Desire*. This book won the "Distinguished Book Award" from the APA Division 44 (LGBT). In this book, Dr. Diamond weighed in on the harm of political activists promoting the "can't change" myth. She acknowledged that, for political motives, some activists "keep propagating a deterministic model: sexual minori-

154 R. Savin-Williams, & K.Joyner,. The dubious assessment of gay, lesbian, and bisexual adolescents of Add Health. Archives of Sexual Behavior, 2014, 43(no. 3): 413-422. See p. 416 for quote. http://dx.doi.org/10.1007/s10508-013-0219-5.
155 For an overview of the debate, see L. Mayer, & P. McHugh, Sexuality and gender: Findings from the biological, psychological, and social sciences, The New Atlantis, A Journal of Technology & Society, Special Report, Fall 2016, 50:1-143. http://www.thenewatlantis.com/publications/executive-summary-sexuality-and-gender
156 Laumann et al. 1994.
157 Savin-Williams & Ream, 2007, p. 389.
158 Dr. Paul McHugh's amicus brief to the SCOTUS on Obergefell v. Hodges.
159 Friedman, R.C. and Downey, J.I., 2002, Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice, New York: Columbia University Press, p. 39.
160 John Gallagher, "Gay for the Thrill of it," The Advocate, Feb. 17, 1998.
161 Diamond, L.M., Sexual Identity, Attractions, and Behavior Among Sexual Minority Women Over a 2 Year Period, Developmental Psychology, 2000, 36(2), pp. 241-250

The SPLC has admitted electric shock is not presently being used at all in psychotherapy to change sexual attraction or behavior. As we will document, so that would mean they admit it is not being used on minors. Is there credible evidence that electric shock has ever been used on children or adolescents to change sexuality?

ties are born that way and can never be otherwise." She addressed the question, "[I]s it really so bad that it is inaccurate?" Her answer was, "Over the long term, yes, particularly because women are systematically disenfranchised by this approach." She said this deceptive practice does harm to women who have experienced sexual attraction fluidity and have "thought there was something wrong with them." She said this "silencing is ironic," because it is being inflicted by the modern lesbian/gay/bisexual rights movement.[162]

In a 2013 lecture to an LGBT audience at Cornell University, Dr. Diamond said, "I feel as a community, the queers have to stop saying, 'Please help us. We're born this way, and we can't change' as an argument for legal standing. I don't think we need that argument, and that argument is going to bite us in the ass, because now we know that there's enough data out there, that the other side is aware of as much as we are aware of it."[163] In other words, she said, "Stop saying 'born that way and can't change' for political purposes, because the other side knows it's not true as much as we do."

A 2016 "Annual Review of Sex Research Special Issue" of the Journal of Sex Research features a review by Diamond and attorney, Rosky. The abstract says, "We review scientific research and legal authorities to argue that the immutability of sexual orientation should no longer be invoked as a foundation for the rights of individuals with same-sex attractions and relationships (ie., sexual minorities)....arguments based on the immutability of sexual orientation are unscientific, given what we now know from longitudinal, population-based studies of naturally occurring changes in the same-sex attractions of some individuals over time.... arguments about the immutability of sexual orientation are unjust...."[164]

In this paper, the authors further said: "We hope that our review of scientific findings and legal rulings regarding immutability will deal these arguments a final and fatal blow."[165]

Diamond and Rosky testify that the immutability claims of activists, such as those in the SPLC, HRC, and NCLR, are "unjust." Diamond testifies such claims cause harm, and the methods of political activists who perpetrate the falsehood inflict "silencing." They lead individuals who experience change in same-sex attractions to think there is something wrong with them and can leave them feeling alone in their experience.

H. No "Electric Shock," "Electroconvulsive Shock," or Credible Evidence of Harm

The SPLC has admitted electric shock is not presently being used at all in psychotherapy to change sexual attraction or behavior. As we will document, so that would mean they admit it is not being used on minors. Is there credible evidence that electric shock has ever been used on children or adolescents to change sexuality?

An extensive research review by an APA task force in 2009[166] concluded there is no research on sexual orientation change efforts for children[167] or adolescents.[168] Although the task force conducted a review of behavior modification research on sexual orientation change efforts, it found no research showing that electric shock has ever been used or coerced on children or adolescents to modify sexuality. In fact, it said there is no research on change therapy for minors whatever. Those who make such claims furnish no scientific research or reliable evidence of such a practice either. The petitioners of this complaint to the FTC do not use electric shock methods, nor do they know of anyone who does, and certainly not with minors.

Historically, aversive methods such as electric shock were used with informed and consenting adult clients by mainstream psychotherapists, especially in the 1960's and early 1980's, as a small, experimental part of the dominant form of psychotherapy at the time called behavior modification. The philosophy of behavior modification was to treat only objectively observable behaviors, not internal experiences per se. Behavior modification provided pos-

162 Ibid., 2008, pp. 256-257.
163 Diamond, L. (Published Dec. 6, 2013). Lisa Diamond on sexual fluidity of men and women, Cornell University. From Diamond, L. (Oct. 17, 2013). Just how different are female and male sexual orientation? Human Development Outreach and Extension Program. https://www.youtube.com/watch?v=m2rTHDOuUBw.
164 Diamond & Rosky, 2016, p. 1.
165 Ibid., p. 3.
166 APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, Washington, DC: American Psychological Association.
167 Ibid, p. 72.
168 Ibid, p. 73.

itive consequences for behaviors a client wanted to increase and aversive consequences for behaviors a client wanted to decrease. When electric shock was used, an adult client chose the level of shock, and the shock was delivered into a muscle in an arm or leg, never the genitals. The use of electric shock was voluntary, not coerced. Aversive methods such as electric shock certainly were not used just for unwanted sexual behaviors. They were also used for cessation of smoking and for alcohol abuse.[169]

Behavior modification was so popular among therapists that an individual practically had to be a behaviorist to be the chair of a psychology department in a college or university. Therapists flocked to huge conferences on behavior modification. Use of electric shock to diminish same-sex attraction stopped, not because of lawsuits, but because the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual, second edition. By the end of the 1980's, behavior modification was being replaced by cognitive behavioral therapy (CBT) that was becoming dominant, and aversive methods such as electric shock went by the wayside.

To our knowledge, psychotherapists have not used electric shock or other aversive methods for decades, and we know of no reliable evidence that licensed psychotherapists ever used electric shock on minors for sexual behaviors. If anyone who was born in recent decades claims they received electric shock or aversive methods from a licensed mental health professional when they were a child, especially for same-sex attractions or gender identity, their claim should be taken with a very large grain of salt. But if there was a case where such a method was used, the claimant should make a complaint to the licensing board in their state, and doing so will stop its use.

There is no evidence that "electroconvulsive shock" was ever used by licensed mental health professionals to modify sexuality, contrary to the claims of the NCLR and Washington state bill HB 2541 quoted above. Electroconvulsive shock therapy (ECT) is a method used by some psychiatrists for the most severe cases of depression, mania, or some other severe psychiatric disorders.[170] Electroconvulsive therapy is not the electric shock method that was used in behavior modification to modify behavior. We know of no instances where clients were caused to convulse from electric shock as a method of modifying behavior or sexuality. There is little doubt that the purpose in using the term "electroconvulsive electric shock" is to alarm and deceive legislators into banning therapy.

The SPLC, HRC, and NCLR claim that therapy with minors that is open to SOGI change results in "suicide" or "death." Opponents frequently cite research by Ryan et al. (2009) about suicide in same-sex attracted minors as if it is about SOCE change therapy, but therapy that is open to SOGI change was not even mentioned in the study, and there was no indication any of the participants had such therapy.[171]

The SPLC, HRC, and NCLR claim that therapy with minors that is open to SOGI change results in "suicide" or "death." Opponents frequently cite research by Ryan et al. (2009) about suicide in same-sex attracted minors as if it is about SOCE change therapy, but therapy that is open to SOGI change was not even mentioned in the study, and there was no indication any of the participants had such therapy.

Opponents not only regularly claim therapy that is open to change employs aversive methods such as electric shock or electroconvulsive shock therapy and leads to suicide and death. Opponents also often claim the American Psychological Association Task Force Report in 2009 found scientific evidence that sexual orientation change efforts are ineffective or harmful, even using such words as "dangerous," "psychologically damaging" or "stark," but such claims are false. Diamond and Rosky are guilty of this, as a review by Rosik penetratingly critiques.[172]

In reality, the APA task force report found research evidence for the safety and effectiveness of both therapy that is open to change and gay-affirmative therapy to be inconclusive. "Inconclusive" just means the task force had no idea. The Task Force also reported that no data for the safety of gay-affirmative therapy existed.[173] Lack of evidence as to whether a

169 D. Byrd & J Phelan, Facts and myths on early aversion techniques in the treatment of homosexual attractions. https://www.narth.com/aversion-techniques-

170 Electroconvulsive therapy and other depression treatments. WebMD, http://www.webmd.com/depression/guide/electroconvulsive-therapy#1

171 Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics, 123, 346-352. doi: 10.1542/peds. 2007-3524.

172 C. Rosik, Research review: The quiet death of sexual orientation immutability; How science loses when political advocacy wins, 2016, http://www.learntolove.co.za/images/Quiet-Death-of-Sexual-Orientation-Immutability.pdf

173 American Psychological Association Task Force., Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, Washington, DC: American Psychological Association.

Yet the evidence that sexual orientation change efforts, or SOCE, are harmful is virtually all anecdotal – the kind of evidence which critics of SOCE refuse to accept with regard to the effectiveness question.

[T]he APA reported anecdotal evidence of both benefits and harms, but ultimately declared that "the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm."

therapy is safe or effective—whether the therapy be heterosexual affirmative therapy or gay affirmative therapy—does not equal evidence that the therapy is ineffective or harmful. Put another way, lack of evidence does not equal evidence of lack.

If lack of conclusive research evidence is grounds for labeling a goal of therapy, "harmful, quackery, snake oil, bogus, consumer fraud" and something that "should be banned," then gay-affirmative therapy, transgender-affirmative therapy, "wait-and-see" therapy, and many other approaches to therapy should be given those same labels and be "banned."

Peter Sprigg, senior fellow for policy studies at the Family Research Council, offered the following analysis of what the APA has said about sexual orientation change efforts in his testimony to the state of Vermont.[174]

> The American Psychological Association (APA), under the sway of ideological opponents of reorientation therapy, has criticized and discouraged (but never banned) reorientation therapy. Yet even the APA acknowledges that: "participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation [attraction], gender identity, sexual behavior, [and/or] sexual orientation identity."
>
> Critics cite another APA statement that there is "no sufficiently scientifically sound evidence that sexual orientation can be changed." This, however, means only that the evidence does not meet all the criteria for "gold standard" social science research, such as large, random samples, a prospective and longitudinal design (tracking people before, during, and after therapy), and use of a control group.
>
> Yet the evidence that sexual orientation change efforts, or SOCE, are harmful is virtually all anecdotal – the kind of evidence which critics of SOCE refuse to accept with regard to the effectiveness question.
>
> ...[T]he APA reported anecdotal evidence of both benefits and harms, but ultimately declared that "the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm."

Psychotherapy, in general, results in harm for 5-10% of adults and 15-24% of minors.[175] For anti-change therapy activists to justify their claims, they would need research that meets scientific standards and demonstrates that harm from therapy that is open to change significantly exceeds the general rate of harm and is prevalent. No such data exists.

Wild anecdotes claiming harm from therapy that is open to change that some opponents' repeat should be carefully checked for validity. The fact is, there are 600 reports of successful sexual orientation change spanning 125 years. Dr. Alfred Kinsey himself, arguably the father of scientific study into homosexuality, helped more than 80 homosexual men make a "satisfactory heterosexual adjustment, which either accompanied or largely replaced earlier homosexual experience." The record includes that he helped "a boy"[176]

Former APA president Nicholas Cummings initiated the 1975 APA resolution that homosexuality is not a mental illness. As Kaiser San Francisco psychology chief, he saw "hundreds" of homosexuals "change and live very happy heterosexual lives."[177] Dr. Robert Spitzer, famous for his parallel resolution to remove homosexuality from the list of mental disorders in the American Psychiatric Association, published research showing change therapy is effective for

174 P. Sprigg, Written Testimony in Opposition to Vermont Bill S. 132, Re: Prohibition of "conversion therapy-"on minors, February 26, 2016. http://www.frc.org/testimony/testimony-by-peter-sprigg-in-opposition-to-vermont-bill-s-132

175 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.; Lambert, M., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. New York, NY: Wiley.

176 Pomeroy, W. (1972). Dr. Kinsey and the Institute for Sex Research. N.Y. Harper and Row. Pp. 75-77.

177 See: N. Cummings, 2011 NARTH Conference: Dr. Cummings, Convention, National Association of Research and Therapy for Homosexuality (NARTH), Phoenix, AZ. See 29:20 min to 33:10 min. https://www.youtube.com/watch?v=B-KxYBch2LVM. Cummings also submitted an affidavit in the SPLC's lawsuit against JONAH.

those who seek it.[178] Rebutting controversy, the editor of the prestigious journal that published the study confirmed the research was sound.[179]

An early report on a current longitudinal research being conducted in response to the APA Task Force recommendations is finding reorientation therapy to be safe and effective.[180] Testimonies of real individuals who actually experienced successful and safe change in sexual attraction through therapy can be found at: Voices-of-Change.org.

V. PETITIONERS' STATEMENT: PROTECT THERAPY EQUALITY FOR MINORS THAT HAVE UNWANTED SAME-SEX ATTRACTIONS OR GENDER IDENTITY

California was the first of a handful of states to ban sexual orientation or gender identity (SOGI) change efforts for minors. Since that time, several states and multiple cities and other jurisdictions have moved to enact similar bans, despite having truthful and scientifically accurate information. Thank you for the opportunity to provide information and share concerns about the unintended consequences we have seen from this anti-change-therapy legislation, and the three organizations discussed in this complaint that are known to be pushing these bills across the country.

Therapy that is open to SOGI change is generally not a form of therapy but openness to a client's freely chosen goal of change using any contemporary form of talk therapy. Contemporary licensed mental health professionals use no coercion or aversive methods. If any exceptions occurred, licensing boards would address these issues. The SPLC, HRC, and NCLR grotesquely misrepresent therapy that is open to a client's goal of change in sexual attraction or behavior or gender identity. Their flagrant and deceptive claims scare minors and adults and are used to deprive children of therapy.

The SPLC, HRC, and NCLR also perpetuate the false and misleading impression that sexual orientation is immutable like skin color. Sexual orientation is not resistant to change; in fact, it is the norm for sexual orientation to change. The American Psychological Association recognizes sexual orientation change.[181] Abundant excellent research has now established that sexual orientation—including attraction, behavior, and identity self label—all three—is fluid for both adolescents and adults and for both genders, and exceptions for LGB individuals are a minority. Change from exclusive homosexual attraction to exclusive heterosexual attraction occurs frequently among adolescents.[182] Sometimes sexual attraction and identity change more than once.[183] Imagine a statement that skin color changes, sometimes from extremely light to extremely dark, in both adolescents and adults and in both men and women, sometimes more than once, and the exceptions are the minority. Such a statement would be absurd. Sexual orientation is not like skin color. "Born that way and can't change" is not true.[184]

The SPLC, HRC, and NCLR also perpetuate the false and misleading impression that sexual orientation is immutable like skin color. Sexual orientation is not resistant to change; in fact, it is the norm for sexual orientation to change. The American Psychological Association recognizes sexual orientation change.

In addition, both the American Psychiatric Association[185] and the American Psychological Association[186] recognize gender identity fluctuates for the vast majority of minors, again, unlike skin color.

Individuals who experience same-sex sexuality and gender variation have a right to know the truth about change. Perpetrating the falsehood that same-sex sexuality and childhood gender variation do not change leaves those who experience change—most individuals who experience same-sex sexuality or childhood gender distress—to think there is something

178 R. L. Spitzer, Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. Archives of Sexual Behavior, 2003, 32(5):403-417. doi: 10.1037/t02175-000.

179 Dreger, A., How to ex an "ex-gay" study. April 11, 2012, Psychology Today Blog. http://www.psychologytoday.com/blog/fetishes-i-dont-get/201204/

180 Pela, C. & Nicolosi, J. (March 10, 2016) Clinical outcomes for same-sex attraction distress: Well-being and change,. Conference of the Christian Association for Psychological Studies (CAPS), Pasadena, CA. http://www.josephnicolosi.com/collection/outcome-research

181 Diamond, 2016, 1:642, in APA Handbook.

182 Udry & Chantala , 2005, found that 48%, nearly half, of exclusively homosexually attracted boys aged 16 became exclusively heterosexual one year later at age 17. Laumann et al., 1994, found that 42% of men who ever had same-sex relationships never did so again after age 18.

183 Katz-Wise & Hyde, 2014.

184 Per research reviews by Diamond & Rosky, 2016, and by Whitehead & Whitehead, 2016.

185 American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Association, pp. 451-459. See especially pp. 455-456.

186 Bockting, 2014, 1:744, in APA Handbook.

Most adolescents and adults who identify themselves as same-sex-attracted will change toward or to exclusive opposite sex attraction. Therapy that is open to change is far more congruent with the norm of change in adolescent and adult sexual attraction development than is gay-affirmative therapy. So it should be successful for some, and how dangerous can it be?

wrong with them, and it subjects them to feeling alone in their experience. As Rosik summarized from Diamond and Rosky:

> "Immutability arguments actually marginalize and stigmatize those who do not experience their sexuality as fixed,"[187] namely, most same-sex attracted minors and adults.
>
> Non-heterosexual adults who have not experienced fluidity themselves are the minority and are more likely to believe sexual orientation is resistant to change for all non-heterosexuals,[188] contrary to abundant and conclusive research.[189] The SPLC, HRC, and NCLR seek therapy bans that privilege minors who do not change over minors who do change or could change with help from therapy, that is, most SOGI minors.
>
> One gets the impression from the SPLC, HRC, and NCLR that same-sex attracted minors and adults are exclusively and permanently same-sex attracted, so attempts to change same-sex attraction are attempts to change a person's essential or core self, hence impossible and harmful. However, abundant research has established that the majority of individuals who experience same-sex attraction (SSA) not only experience change in sexual attraction, they also already experience opposite-sex attraction (OSA). In fact, the majority of individuals who experience SSA are mostly opposite sex attracted (mostly OSA). These mostly heterosexual individuals are greater in number than all other individuals with gay, lesbian, and bisexual attractions combined. The majority of bisexually attracted individuals experience change toward or to exclusive heterosexual attraction. The majority of mostly heterosexually attracted individuals undergo a complete transformation to exclusive heterosexual attraction.[190]
>
> Some who are attracted to both sexes are in heterosexual relationships and desire therapy to help them be faithful and keep their families together. Some youths are not yet in relationships, but they aspire to have faithful heterosexual relationships and families and need therapy assistance to fulfill their potential to do so. The SPLC, HRC, and NCLR create a false portrayal of sexual orientation that excludes them—the vast majority of same-sex attracted individuals— and deprives them of therapy appropriate to their needs.
>
> Most adolescents and adults who identify themselves as same-sex-attracted will change toward or to exclusive opposite sex attraction. [191] Therapy that is open to change is far more congruent with the norm of change in adolescent and adult sexual attraction development than is gay-affirmative therapy. So it should be successful for some, and how dangerous can it be?[192]
>
> According to the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5) and the *APA Handbook of Sexuality and Psychology*, as many as 75%[193] to 98%[194] of gender dysphoric boys and as many as 75%[195] to 88%[196] of gender dysphoric girls eventually accept their chromosomal sex. Therapy that is open to change is far more congruent with the norm of gender dysphoria development in minors than is transgender-affirmative therapy, so it should be successful for some, and how dangerous can it be?
>
> There is credible scientific evidence that childhood sexual molestation[197] and parent absence through death, divorce, end of parent co-habitation, or unknown paternity are potentially causally linked to same-sex sexuality.[198] Some individuals would like to decide for them-

187 Rosik, 2016, p. 10.

188 Katz-Wise & Hyde (2014). Sexual fluidity and related attitudes and beliefs among adults with a same- gender orientation. Archives of Sexual Behavior. DOI 10.1007/s10508-014-0420-1.

189 See these reviews: Diamond, L. (Published Dec. 6, 2013). Lisa Diamond on sexual fluidity of men and women, Cornell University. From Diamond, L. (Oct. 17, 2013). Just how different are female and male sexual orientation? Human Development Outreach and Extension Program. https://www.youtube.com/watch?v=m2rTHDOuUBw; Diamond & Rosky, 2016; APA Handbook, 2014; Whitehead & Whitehead, 2016.

190 Diamond & Rosky, 2016, p. 7 and Table 1; Savin-Williams, Joyner, & Reiger, 2012, APA Handbook, 2014.

191 Udry & Chantala, 2005; Savin-Williams & Ream, 2007; Laumann et al., 1994.

192 Savin-Williams & Ream, 2007; Savin-Williams, Joyner, and Rieger, 2012; see analysis of these studies in Whitehead & Whitehead 2013, Ch.12, pp. 231-235.

193 American Psychiatric Association, 2013, DSM-5, calculated from p. 455.

194 Bockting, 2014, 1:744, in APA Handbook.

195 American Psychiatric Association, 2013, DSM-5, calculated from p. 455

196 Bockting, 2014, 1:744, in APA Handbook.

197 Rosario & Shrimshaw, 2014, 1:583, in APA Handbook; Tomeo, ME, "Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons." Arch Sex Behav. 2001 Oct;30(5):535-41.

198 Frisch, M. and Hviid, A., Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes.,Archives of Sexual Behavior, 2006, 35:533-547; Francis, A. M., Family and sexual ori-

selves whether their sexual orientation or gender identity (SOGI) represents an authentic or positive variation of sexuality for themselves. No activist organization, professional organization, or legislature should decide that for others. A position that sexual variation is always normal and positive marginalizes and stigmatizes those who are experiencing a painful link between trauma, parent loss, other psychoanalytic injuries, and same-sex sexuality.

The SPLC, HRC, and NCLR have, through propagating falsehoods to legislatures, caused therapy to be denied to heterosexual children who had same-sex sexuality forced on them through childhood molestation. These children specifically want therapy that will help them CHANGE their attractions and behavior. Depriving children of therapy to help them change same-sex attraction or behavior abuses victims of childhood sexual abuse.

All have a right to know that non-heterosexual orientation and childhood gender confusion change spontaneously in most cases and therapy assistance may be needed to help.

Therapy that is open to change seeks to help parents love their same-sex attracted (SSA) or transgendered or gender non-conforming (TGNC) minor who may have suffered psychological injuries and respect their child's wish to have or not have therapy that is open to change.

The American Psychiatric Association could not conclude whether various therapeutic approaches for children—to change gender dysphoria, to affirm TGNC identity, or to "wait and see"—affected whether gender dysphoria persisted or changed, because no systematic longitudinal studies of gender dysphoric children exist, nor can conclusions be made on safety or harm of these various psychotherapeutic approaches.[199]

Bocking says in the *APA Handbook* that there is evidence of pathology in the etiology of transgender or transsexual identity.[200] He warns against early social transitioning, because most children will eventually identify with their chromosomal sex, but transitioning may foreclose a child's gender identity development.[201] If the child transitions back to identifying with the chromosomal sex, it may be challenging to reverse the social role, and the stress of doing so has been shown to be substantial.[202] Early social transitioning also risks neglecting individual problems that the child might be experiencing.[203] Children should be able to receive therapy for such problems that may be leading to their transgender identity. Unfortunately, opponents seek to deprive such children of therapy, contrary to the advice of Bockting in the authoritative *APA Handbook of Sexuality and Psychology*.[204]

Protocols for chemical transitioning of transgender adolescents and adults are based on research that is rated to be of poor and very poor quality. It is known that puberty blocking hormones and cross-sex hormones (testosterone and estrogen) are associated with dangerous health risks.[205]

Changes in sexuality are not only spontaneous. Sexual orientation also may change through an individual's choices. On choice, Rosik quotes Diamond and Rosky this way, in a not-so-subtle rebuke to the APA, the authors observe that, "Both scientists and laypeople commonly claim that same-sex sexuality is rarely or never chosen (e.g., American Psychological Association, 2008), and individuals who claim otherwise (or who imply the capacity for choice by using terms such as sexual preference instead of sexual orientation) are often interpreted as misguided, insensitive, or homophobic. Yet similar to bisexuals, individuals who

Protocols for chemical transitioning of transgender adolescents and adults are based on research that is rated to be of poor and very poor quality. It is known that puberty blocking hormones and cross-sex hormones (testosterone and estrogen) are associated with dangerous health risks.

entation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 2008, 45 (4):371-377. DOI:10.1080/00224490802398357; Udry, J.R., & Chantala, K., Risk factors differ according to same- sex and opposite-sex interest. Journal of Biosocial Science, 2005, 37, 481–497. http://dx.doi.org/10.1017/S0021932004006765.

199 American Psychiatric Association, 2013, DSM-5, p. 455.

200 Bockting, 2014, 1:743, in APA Handbook.

201 Ibid., 1:744.

202 Ibid., 1:744, 750.

203 Ibid., 1:750.

204 Bockting, 2014, 1:743-744, 750, in APA Handbook.

205 See: Olson-Kennedy, J and Forcier, M. (November 4, 2015). "Overview of the management of gender nonconformity in children and adolescents." UpToDate. http://www.uptodate.com/contents/overview-of-the-management-of-gender-nonconformity-in-children-and-adolescents?source=search_result&search=overview+of+the+management+of+gender+nonconformity+in+children+and&selectedTitle=1%7E150; Hembree, W. C., et al. (2009) Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. J Clinical Endocrinology and Metabolism.; 94: 3132-3154. http://press.endocrine.org/ doi/pdf/10.1210/jc.2009-0345; Moore, E. Wisniewski, A. & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. The Journal of Clinical Endocrinology & Metabolism 88(9):3467-3473. doi: 10.1210/jc.2002-021967. http://press.endocrine.org/doi/pdf/10.1210/jc.2002-021967.

Many minors who actually do have same-sex attraction or gender distress think their experience is something they are born with that can never be otherwise, potentially leading to depression, anxiety, and suicidal thoughts for some minors, excessive distress for their parents and families. These beliefs also lead to depression and anxiety for some adults, and excessive distress for the spouses and children of same-sex attracted adults who may fear marriage and family breakdown as a result. Attacks on therapy add to these harms.

perceive that they have chosen some choice in their same-sex sexuality are more numerous than most people think."[206]

What we know is that sexual orientation ordinarily changes, some individuals change by choosing to change, and same-sex sexuality is potentially causally linked to childhood molestation, parent absence, or other psychoanalytic factors that are treatable. Since we know these things, it makes little sense to say the only place where sexual orientation does not change is in therapy. We also know childhood gender dysphoria usually resolves toward the child accepting the chromosomal sex by adulthood if allowed to, and the condition may be due to pathology. Childhood gender dysphoria, too, should be changeable in therapy.

All have a right to know that therapy that is open to a goal of change is an option by which some, though not all, make a significant and meaningful shift in their sexual orientation or gender identity. A research review of "600 reports of clinicians, researchers, and former clients—primarily from professional and peer-reviewed scientific journals" conducted over "125 years of clinical and scientific reports...documents[s] that professional-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."[207]

VI. CONCLUSION

The HRC, SPLC, and NCLR have been documented in this report to be actively promoting harmful, dangerous, deceptive, and misleading campaigns to mislead and deceive the public and shut down licensed therapists who are helping clients distressed by unwanted same-sex attractions and gender identity confusion. The National Task Force for Therapy Equality respectfully asks the Federal Trade Commission to review their hate campaigns and immediately order them to cease operating.

The SPLC, HRC, NCLR, and others are continually portraying that same-sex attractions comes in two types, gay and straight, that are fixed at birth and never change, like skin color. Their portrayals also create the impression that the probability of being LGBT is far higher than it actually is. Gallop polls indicate these organizations, along with other willing organizations and individuals, have successfully convinced a majority of the American public to believe these deceptions.

A Gallop poll also shows the public has believed that the large numbers of LGBT displayed to them in the media accurately indicate how many people of LGBT. Gallop reported: "The American public estimates on average that 23% of Americans are gay or lesbian, little changed from Americans' 25% estimate in 2011, and only slightly higher than separate 2002 estimates of the gay and lesbian population. These estimates are many times higher than the 3.8% of the adult population who identified themselves as lesbian, gay, bisexual or transgender in Gallup Daily tracking in the first four months of this year.

There is anecdotal evidence that many adolescents think there is a high probability they could be LGBT, and they are worried over it. Teens are straining to detect whether they might be same-sex attracted based on very little evidence. They are wondering, if they admire another teen of their own sex that does mean they are gay? If there is any indication of any degree of potential same-sex attraction, that would mean they are gay, and only if there is none would it mean they are straight, with no in-between.

Whichever it is will be permanent and determine their future. Parents are hearing from their children that their children are confused, worried, and even downright panicked. Many youths are wondering whether they are transgender. Not only is the extreme and false message of sexual variations being delivered, but there is anecdotal evidence it is being concerningly overdone. Research evidence indicates that unsure youth turn out to be heterosexual, but for many of them, worrying over what their sexual orientation or gender identity is has

206 Rosik, 2016, p. 11, quoting Diamond & Rosky, 2016, p. 20.

207 What Research Shows: NARTH's Response to the APA Claims on Homosexuality (Summary), p. 1, Family Watch International, http://www.familywatchinternational.org/fwi/NARTH_what_research_shows.pdf; The summary was of a full article, J. Phelan, N. Whitehead, & P.M. Sutton, 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, 2009, Journal of Human Sexuality, 1: 1-121. Available at https://media.wix.com/ugd/ec16e9_04d4fd5fb7e044289cc8e47dbaf13632.pdf

become one more thing adolescents are having to worry about without good reason, and their parents and teachers do not have the accurate knowledge to help them through it either.

Many minors who actually do have same-sex attraction or gender distress think their experience is something they are born with that can never be otherwise, potentially leading to depression, anxiety, and suicidal thoughts for some minors, excessive distress for their parents and families. These beliefs also lead to depression and anxiety for some adults, and excessive distress for the spouses and children of same-sex attracted adults who may fear marriage and family breakdown as a result. Attacks on therapy add to these harms.

The public should have a right to know that no one is born with a same-sex sexual orientation or transgender or nonconforming identity. Adolescents and adults should have access to accurate scientific knowledge that same-sex attraction, behavior, and self-label identity as well as childhood gender distress change for most, mostly toward or to the norm of heterosexuality and identity with ones chromosomal sex.

Individuals should have the right to know that many, though not all, make a significant and meaningful shift in their same-sex attraction or gender identity variation, some of them assisted by therapy that is open to their goal of change. In the best study on adolescents, 89 percent of same-sex attracted boys changed, and in just one year. Only 11 percent did not change. The SPLC, HRC, and NCLR make a claim (which has poor empirical support) that "reorientation therapy may harm the self-esteem of those who do not change"—the 11% in this study. But it makes no sense to address that theoretical harm by hiding the truth from, and denying help to, the 89% of teens who may lose, or overcome, their same-sex attractions," explains Peter Sprigg, senior fellow for policy studies at Family Research Council.[208]

For those who do not change in therapy, not all regret that they tried. Therapy has many benefits. Laws that ban therapy privilege those who do not experience sexual orientation or gender identity change over those who do and who are the majority.

There are other harmful results of the "can't change" deception being perpetrated by the SPLC, HRC, and NCLR. Individuals with same-sex attractions who change, the majority, are left to feel there is something wrong with them and that they are alone in their experience.[209] Another harm of the "can't change" falsehood is that children with a gender identity variation who believe they are born that way and can never change may pursue hasty social transitioning of gender identity or even premature chemical or surgical gender transitioning contrary to the advice of the *APA Handbook of Sexuality and Psychology*.[210] It is tragic that minors may permanently remove healthy parts of their own bodies and render their bodies forever infertile when, if allowed, they more than likely would come to accept their chromosomal sex.

The SPLC, HRC, and NCLR conspire to keep from the public the knowledge that some children had same-sex attraction forced on them because a pedophile or older adolescent sexually abused them. For some children, absence or loss of a biological parent, especially a parent of the same sex as the child, affected the development of the child's sexual orientation. Other psychoanalytic or social environmental factors may also have diverted a child's sexual orientation.[211]

Some of these children do not experience their sexual variation as normal or authentic for them. They are marginalized by the generalization that sexual variation is always normal. They desire therapy to help them change their unwanted sexual attraction or behavior. Treatment for links between their sexual variation and childhood sexual molestation, the effects of an absent parent—especially the parent of the same-sex as the child, or other social environmental factors could lead to a significant and meaningful shift in that variation for some. The SPLC, HRC, and NCLR seek to make helping these children change their sexual attraction or behavior illegal. Banning therapy for children whose sexual orientation or gender identity may have been injured also bans speech about such realities from therapy.

Some individuals who have changed through therapy have regretted that these political organizations, some professional organizations, their culture, or their family led them to believe they could not and should not try to change their sexual attraction or behavior through therapy. They feel they have lost years of their lives that could have been lived the way they are now able to live because they finally did have therapy.

208 Sprigg, P. (February 26, 2016). Testimony delivered against S. 132. Retrieved online from: http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Senate%20Health%20and%20Welfare/Bills/S.132/S.132~-Peter%20Sprigg%20-%20Family%20Research%20Council-Written%20Testimony%20-%20Opposition%20to%20the%20Bill~3-11-2016.pdf

209 Diamond, 2008, pp. 256-257.

210 Bockting, 2014, 1:744, 750, in APA Handbook.

211 Rosario & Schrimshaw, 1:583, in APA Handbook; Bockting, 2014, 1:743, in APA Handbook.

Coercing any goal of therapy on a client is unethical, because it violates the client's right to self-determine the goal of therapy and risks being ineffective and harmful.

Therapy bans for these children are cruel and unjust. In effect these children are victimized twice, first by their sexual abuser or other life injuries, and second by these organizations that deprive them of therapy. Heterosexual-affirming therapy is more appropriate for them than gay affirmative therapy, but opponents want them only to have a choice of gay-affirmative therapy or therapy that will not lift a finger to try to help them change their attractions and behaviors to match who they feel themselves most authentically to be.

Some individuals who have changed through therapy have regretted that these political organizations, some professional organizations, their culture, or their family led them to believe they could not and should not try to change their sexual attraction or behavior through therapy. They feel they have lost years of their lives that could have been lived the way they are now able to live because they finally did have therapy.

A small minority of states has banned therapy that is open to sexual variation change. Lawmakers in these states failed to foresee that individuals who are distressed by their unwanted sexual orientation or unwanted gender identity are not going to go to a gay-affirmative or gender-variant-affirmative therapist or a therapist who does not share their values and whom they do not trust. They are now being sent to unlicensed counselors or getting no help at all. These minors are not being served. Some have been victims of sexual abuse and are suicidal. Some aspire to live according to their chromosomal gender or to be faithful in a heterosexual relationship with family, as do most individuals.

Therapists should not have to abandon such individuals under threat of being thrown out of their professional organizations, losing their licenses, or being bankrupted. Banning sexual orientation or gender identity change efforts for individuals who desire it has been harmful and ineffective.

It should not be missed that laws banning openness to sexual variation change place all therapists in a dangerous trap — regardless of their view on sexual orientation, gender identity, or therapy that is open to change. If a client desires help to change sexual attraction or behavior, it is unethical for any therapist to provide gay- or gender-variant-affirmative therapy, because the client does not want it. Coercing any goal of therapy on a client is unethical, because it violates the client's right to self-determine the goal of therapy and risks being ineffective and harmful.

The therapist cannot provide or refer the client for therapy that is open to change, because doing so is against the law. Ethically, the therapist cannot abandon the client. If the therapist agrees to treat the client for other concerns though not for the goal of changing sexual attraction or gender identity, there is the real possibility that fluidity, fluctuation, or change in the client's sexual orientation or gender identity will occur, and then it is an open question as to whether the therapist may be in violation of the law. At least, the therapist is opened up to liability.

Some therapists are afraid of treating adolescents who want therapy that is open to sexual orientation or gender identity change, and at the same time, they are afraid of discriminating against taking some adolescents as clients based on unwanted sexual orientation, unwanted gender identity, or goal of therapy. An unintended consequence of the laws passed already in a handful of states has been that some therapists are discerning that their only protection is to stop treating all adolescents or all adolescents who have unwanted same-sex attraction or unwanted gender variation, and most especially if they want therapy to explore their potential for sexual variant change.

Some sexually variant minors are already being turned away from professional mental health services. For example, the California Board of Behavioral Science has been asked more than once to clarify the law on this very liability question and has declined. All banned providers and their sexually variant minor clients are endangered. Bans on sexual orientation or gender identity change efforts are not safe or effective, and the work of HRC, SPLC, and NCLR are actively putting minors, and their families, in danger of not receiving competent, qualified mental healthcare while deceiving consumers and the general public. We respectfully ask you to put an end to these dangerous and deceptive hate campaigns so that future lives can be saved.

SIGNATORIES

American College of Pediatricians
Christian Medical and Dental Associations
Alliance for Adolescent Health
Family Watch International
Voice of the Voiceless
Center for Family and Human Rights
Alliance for Therapeutic Choice and Scientific Integrity
Jewish Institute for Global Awareness

NARTH COMMITTEE RESPONSE TO APA REPORT
September 11, 2009

Contents:

Response to the APA report "Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation."

N.E.Whitehead, Ph.D.

Summary:
This paper asserts that the APA's labeling of homosexuality as "normal" is a value judgment which, contrary to the task force's assertion, does not come from science. It further asserts that the extreme health risks homosexual males take is *ipso facto* a treatable mental illness. It also argues that the failure of the task force to understand the intellectual history of what causes homosexuality, means its criticisms of sociological surveys supportive of traditional therapies are misconceived. The genesis of homosexuality is so individualistic that sociological surveys often fail to capture the individualistic threads, and individual case studies should have been emphasised. The alternative gay-affirmative therapies advocated by the committee are relatively untried and demand an even higher standard of proof than that demanded for the traditional therapies.

"Normal" is a value word not a scientific word

In this paper those therapists who offer the possibility of change to homosexual people are called "traditional therapists", because as mentioned (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009) this therapy has a history covering much of last century.

There are many of us out here, who believe several of the basic positions of the APA on homosexuality are scientific nonsense and have believed this for 30 years and more (specifically the alleged normality of the condition and the alleged lack of accompanying pathology). Some of this occurs again in the report..

The most basic bit of philosophical nonsense in the report is that it is a scientific fact that homosexuality is normal. Use of this principle is advocated by the task force as a means of educating people that it is ethically OK to be homosexual. It is a very clear ethical value judgment. As a practicing scientist I say that this statement of normality is either completely vacuous or elevates science into a religion, both of which are deplorable..

If the statement that homosexuality is normal means that homosexuality is widespread, occurs in society, and this is established as a scientific fact, we agree the surveys show it is widespread. But to tack the value-word "normal" onto it is elementary nonsense. Anyone in introductory philosophy classes learns that it is a logical fallacy to say that because something IS, that it is right or wrong. (The task force cannot mean this

otherwise it must say that therapies which attempt to treat homosexuality are also normal and right by virtue of their existence)

Science can only be made to say that some things are right or wrong or "normal" if it has become the slave of religious or philosophical ideology. Value statements about homosexuality do not come from science but politics. Saying the concept of ethical normality comes from science is attaching a false authority to their statement.

Mental illness

The APA well knows that very many still hotly contest their view that homosexuality *per se* has no intrinsic element of mental illness associated with it. The view of traditional therapists can be summed up thus:

At the most extreme a large fraction of homosexual men prefer death to adopting safer sex.

Although not an explicit DSM standard this is obviously a mental illness. Any responsible therapist, if asked, would treat such a condition.

The authors of the report list reasons for seeking therapy, and fear of health consequences is not listed - or is perhaps very minor. Assuming this is true, it is remarkable, and further evidence of cognitive disturbance.

(This applies to extreme promiscuity in the heterosexual sphere as well, but in the West the risk of death from heterosexual hypersexuality is so low that it is rarely mentally aberrant in that sense.)

Presenting to the public the idea that there is no mental illness associated with homosexuality is highly misleading.

Standards of proof

Therapists have been offering therapies to help homosexuals for many decades. However the task force now demands a standard of proof of effectiveness which appears impossibly high and is not required of other therapies. A good name for this might be "victimization". The "success rates" of various therapies for addiction are similar to those for homosexual-related therapy – but addiction therapies (for example) are never attacked on the grounds that they have not been subjected to the impossibly rigorous tests proposed for traditional therapy for homosexuals. The only rigorous survey would be a longitudinal comparison of "treatment" and "no treatment". But presenting clients usually have co-morbid problems particularly suicidality, mood disorders and substance abuse so "no treatment" is not an ethical option. This means a rigorous test is impossible. The Task Force's insistence on such high standards of proof for traditional homosexual

therapies is so highly selective it can only be political, and is hence very reprehensible in an organization trying to give an impression of being wholly science-based.

Would the committee recommend that therapy for alcoholism be not attempted because it will probably not work? Statistically the truth is that in most cases it doesn't. The ethical position must surely be that anything that may work should be tried, though with appropriate safeguards.

Along with this an alternative gay-affirmative therapy is advocated. Given the Task Force's stated position, the same research standards must be applied to testing whether affirmative therapy works. In fact higher standards must be demanded because it is largely untried compared with the wealth of experience gained over many decades for the traditional therapies. Some common sense is needed. Traditional therapies which advocate at least same-sex sexual abstinence, must save many lives, even if no good survey has been done to support that. An alternative therapy which allows or encourages expression of an intense sexuality which often causes premature death through misadventure must meet extremely high standards of proof to be declared safe. Probably such experimental treatment is currently unethical.

Spontaneous change in attraction

A basic point of contention is whether attractions change. The literature shows that same-sex attraction is much more basic and less socially constructed than modern gay identity. The question is: can/do attractions change? The authors did not adequately review the significant literature which mentions how surveys show spontaneous change in attractions takes place. This has been well known since the time of Kinsey who reported many such cases of change to greater or lesser degrees. This has been followed by many such reports. Approximately 3% of the heterosexual population once believed they were homosexual or bisexual because of the appropriate attractions. Significant change in attraction takes place in both directions on the heterosexual-bisexual-homosexual continuum(Kinnish, Strassberg, & Turner, 2005). This is not adequately described as merely "fluidity". If spontaneous change takes place, surely therapeutically assisted change has an even better chance?

Misinterpreted research, ignorance of intellectual history

The report contains a complete misinterpretation of the intellectual history of research into homosexuality. Following a common and completely mistaken thread they assert that the work of Bell, et al. (Bell, Weinberg, & Hammersmith, 1981) and their successors showed that no family factor has any effect on the genesis of homosexuality. This is quite wrong, as discussed in the successful replication of their work by Van Wyk and Geist (Van Wyk & Geist, 1984). The paths to adult homosexuality Bell et al. found, accounted for 30% of the variance, which is a good and significant result by the standards of sociological surveys. This *unequivocally* means that social factors *as a whole* are significant. (But other factors are also involved, since less than half the variance is accounted for). However Bell et al also found that any *individual* path or sequence

although statistically significant had a very small effect size (in today's terminology). No individual path is the dominant one as amply confirmed by much other research. Nor will exposure of individuals to any known factor cause more than a very small proportion to become homosexual. This shows clearly that there are a large number of individualistic reactions and social-factor paths to the end point of adult homosexuality. It means that because many social factors are involved that therapy has a chance of promoting change. It also means that sociological surveys of homosexuality have a strong chance of not capturing truth for individuals, e.g. significant change.

The problem here is a confusion between a sociological viewpoint and a clinical one. (Whitehead, 1996) Sociological surveys give the grand mean for a group of people but must ignore individual particularities. Sociologists have a bad tendency to make incorrect claims about individuals based on sociological surveys which hide individual differences. Conversely a clinician may gain great insights about individuals from in depth interviews. However clinicians have a bad tendency to make incorrect claims about the general population based on their limited sample.

Subsequent intellectual history not mentioned by the task force supports the above interpretation. The consistent outcome of extensive twin studies, (Hershberger, 1997), (Bailey, Dunne, & Martin, 2000), (Kendler, Thornton, Gilman, & Kessler, 2000; Bearman & Bruckner, 2002), (Santtila et al., 2008), (Langstrom, Rahman, Carlstrom, & Lichtenstein, 2008) is that there is a combined dominant cause of homosexuality but it is the class of individual non-shared experience, or more probably different reactions to the same experiences, exemplified by the fact that if one identical twin has same sex-attraction the co-twin overwhelmingly does not. No shared factor, social or genetic is predominant.

Since the science establishes that there is a primacy of the *individual* experience, criticisms of the methodological weaknesses of surveys are a pointless counsel of perfection. Therapies, and individual experiences are so varied that it is most impressive there is any coherence at all in the overall picture captured by surveys. These changes are more striking when they are in the form of individual stories, and it is those which are most important.

Because in any therapy (sexual or not) some do not change, some change a little and some change a lot, testing whether change is real or possible (the point at issue here) should not use the average of a sociological survey, which will only show a small or even non-significant change on average, but the reality/or otherwise of the greatest change for any individual in the group. This is a illustration of what change is potentially possible. Looking closely at the factors involved, skilled therapists then learn how to improve their therapy.

Client satisfaction is a crucial factor in this. It is a valid therapeutic endpoint. The account by the client is paramount. If the client is satisfied with what he/she sees as change, that is change for them.

It may be of theoretical interest to cross question clients very deeply to see characteristics of the change, but our experience is that the current scepticism which drives this is so intense that it can easily amount to a form of intellectual rape. Well enough should be left alone. We find that the most intense questioning comes from those who have not changed, and project their experience onto the population at large. This is quite invalid of course. One individual who testifies to change that satisfies them, outweighs a thousand who have not changed.

We note that the task force treats the sociological survey as the overwhelmingly important methodology for the present investigation, which given the fact that their organization is psychological and would normally put first emphasis on the clinical story is astounding. The sociological is not their primary expertise, and in this case is greatly misapplied.

Stress from minority status has very little empirical support

The authors mentioned coping style, but did not mention that the work of Sandfort et al. (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009) found that differences in coping style accounted for *all* the variance in mental health in their homosexual subjects leaving no room for minority stress. Nor did the task force mention the literature which failed to find much influence of minority stress when searched for, nor the epidemiological work which found for gay-friendly countries such as the Netherlands (Sandfort, de Graaf, Bijl, & Schnabel, 2001) and New Zealand (Fergusson, Horwood, & Beautrais, 1999) that mental health problem prevalence for gays and lesbians were about the same as in the USA (Herrell et al., 1999). Much subsequent work confirms these studies. Minority stress is an attractive hypothesis much canvassed, but has almost no empirical support. Subsequent research concluded that "the risk attached to minority sexual orientation seems to cut across ethnic/racial backgrounds and international boundaries." (Cochran & Mays, 2008)

The authors might reflect that the existence of the traditional therapies has continued for at least 35 years in various forms in spite of a remarkably hostile climate. Neither therapists nor clients have found these therapies in general so unrewarding that they have abandoned the project. There continue to be clients and therapists. This kind of real-life sociological experiment means that traditional therapy clients and their therapists are about as satisfied as is found in other established therapeutic fields.

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Does the APA Report Apply its Research Methodology Standards Consistently? A Preliminary Examination

Christopher Rosick, Ph.D.

The APA's recent task force report, entitled, "Appropriate Therapeutic Responses to Sexual Orientation," contains a major section dedicated to identifying the methodological problems in the research on sexual orientation change efforts (SOCE). This section is meticulous in its efforts to identify any and all limitations to SOCE research with a clear aim of discrediting this literature. While no body of research is free from limitations, one measure of the degree of objectivity behind critiques of this nature is the extent to which they are uniformly applied to research affirmed by the reviewers.

In the case of the APA's report, I was able to locate two articles cited by the task force that was available in full text in the EBSCO database. Research by McCord, McCord, and Thurber (1962) is cited in support of repudiating theories that sexual orientation is associated with family dynamics, gender identity, and trauma. A more recent study by Kurdek (2004) is reported by the task force in support of the essential similarity between gay, lesbian, and heterosexual couples.

A review of the task force's methodological critique of SOCE identified 16 separate concerns that, in the eyes of the task force, are each significant enough on in themselves to call the SOCE research findings into questions. I have listed these concerns in Table 1. My preliminary methodological examination of these articles suggested that, by the APA task for standards, the McCord et al (1960) research committed 10 of the 16 (63%) problems while 2 (13%) additional problems could not be evaluated. The Kurdek research faired slightly better, with only 8 (50%) methodological problems identifiable and another 3 (19%) either not applicable or not able to be evaluated. I will review some of the problems in these studies below, and the reader should keep in mind that these studies were cited uncritically in the task force report.

McCord et al study. The McCord et al (1962) study examined data among a sample of boys between the ages of 10 and 15 culled from observational records charted 12 to 18 prior to their investigation. The researchers examined a number of variables ascertained from the records and generally sought to determine whether these variables differed among boys from home with or without a father present. They reported homosexuality did not differentiate between boys with fathers present and those with

absent fathers. However, methodological problems highlighted by the APA task force were evident from the start.

Attrition pared the original convenience sample of 325 down to 255. The final sample included 150 boys from intact families and only 55 who had father absent families with no randomization process in selecting these groups. Consequently, some of the cell sizes were very small. Nearly all dependent measures (e.g., "affectional interaction," "homosexual tendencies") were not clearly defined and where defined the terms used in these definitions were similarly vague. Moreover, no validity or reliability information was presented relative to these set of ratings that comprised variables such as homosexual tendencies. The relationship between homosexual tendencies and sexual orientation (a term never used in McCord, et al) is far from clear, even though the APA task force appears to assume they are commensurate. The sample was restricted to low SES boys. The article further does not make clear to what extent the researchers reviewing the records were aware of the study's purposes.

Kurdek study. Kurdek (2004) compared longitudinal data obtained from gay and lesbian cohabiting couples and partners from heterosexual married couples with and without children, examining five domains of relationship health and determining if similar variables predicted relationship stability for these couples. Kurdek found that where differences between same-sex and heterosexual couples did exist, over two-thirds of these indicated gay and lesbian partners functioned better than heterosexual partners. The author concluded that the processes that regulate gay and lesbian relationships are the same as those that regulate heterosexual partners.

Methodological problems that, if consistently applied, would lead the APA task force to raise questions regarding Kurdek's (2004) conclusions begin with his sampling procedures. Different methods were used to obtain the convenience samples of heterosexual and same-sex couples. Heterosexual couples were recruited through marriage announcements published in a daily newspaper. Same-sex couples were recruited through gay and lesbian periodicals, and these participants in turn were encouraged to recruit additional same-sex couples. Thus, selection and response bias may well have been a factor, especially in the recruitment and responses of same-sex participants. However, no measure of test-taking attitude was included that could have addressed this concern.

The longitudinal waves consisted of subsamples of participants, as attrition appeared to take a significant toll over the eight assessment periods. At first assessment, there were 80 heterosexual couples with children, but by the eighth assessment, only 50 remained. The *N* for heterosexual couples without parents declined from 146 to 29, gay couples decreased from 80 to 33, and lesbian couples diminished from 53 to 52. The sample was also restricted primarily to White and college educated individuals. The article did not present descriptive information for the correlational analyses that would permit evaluation of the extent to which univariate and multivariate assumptions had been met. Nor was the global evaluation outcome variable defined in a clear manner. In all instances, the variables studied were derived from self-report measures.

Other methodological concerns were evident in this research beyond those identified by the APA task force. While these will not be detailed for this analysis, one does bear mentioning in the present context. Specifically, Kurdek (2004) noted that same-sex couples were added to the sample at two points over the entire assessment

period, meaning gay and lesbian couples did not have the same number of possible assessments. This is reminiscent of the Jones and Yarhouse (2007) study of ex-gays, were the authors added to their sample of participants in religiously based SOCE. This sample addition was touted by critics as a serious methodological flaw that introduced bias into the research. While the two studies have different aims and foci, an equally applied methodological critique would certain raise concerns about the bias that Kurdek might have introduced into his sample of same-sex couples by adding additional subjects after the initial assessment period.

Conclusion. Serious concerns about the APA task forces' objectivity have to be raised if this preliminary investigation is at all indicative of the methodological problems which exist in the literature cited uncritically to dismiss non-equivalency theories concerning sexual orientation etiology and relational functioning. Certainly in the present analysis of the McCord et al (1962) and Kurdek (2004) studies, had the task force applied their SOCE methodological critique with similar rigorousness, they would have been unable to cite these studies in any sort of generalized or conclusive manner. Yet such certainty is precisely what the APA task force seems to imply in their report. This disparate treatment of the SOCE literature in comparison to other sexual orientation research both reflects the lack of ideological diversity on the task force and the essential sociopolitical nature of the report. This, in turn, casts significant doubt upon the impartiality and accuracy of the APAs conclusions regarding SOCE.

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Table 1

Methodological Problems in the SOCE Research as Identified by the APA Task Force

Research Design	Problem
Experimental/ Quasi-Experimental Designs	
	Lack of comparison group/No treatment controls
	Lack of multiple baseline assessments
	No randomization to conditions
	Lack of multiple long term follow up assessments
	Significant sample attrition
	Retrospective pretests
All Designs	
	Lack a clear definition of terms
	Relies on self-report measures
	Relies on measures of unknown validity/reliability
	Participants not blind to study purposes
	Small sample size
	Violation of statistical assumptions
	Skewed distributions
	Narrow sample composition (e.g., homogeneity)
	Convenience sample (vs. population-based)
	Recruiter/selection bias

"The Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation": Comments on its Problematic Legal Perspective.

Keith Vennum, Ph.D.

(Overall Summary) "Even though the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality," Nothing in the report demonstrates that same-sex sexual and romantic attractions, feelings and behaviors are **positive**. Positive suggests they are in some way beneficial to an individual when in fact the report points out that such behaviors are often associated with **negative** mental health and physical health states and therefore one could accuse the APA of misleading confused or questioning individuals to negative mental or physical consequences by supporting their behaviors as positive. This opens the door for such an individual to bring a cause of action against the APA should they experience negative consequences from the same sex behavior much in the same way that cigarettes were once promoted as healthy by their manufacturers.

(Overall Summary last paragraph) The phrase "affirmative therapeutic interventions" is purposely unclear. All therapists want to be affirmative to their clients but in this case affirmative is not defined until (page 11 or 19 of 138) "This approach to psychotherapy is generally termed *affirmative*, *gay affirmative*, or *lesbian, gay, and bisexual (LGB) affirmative*." By writing the report in this manner the phrase "gay affirming therapy" could be inserted where ever the word affirmative appears in the report. It is understood in this manner by LGBT therapists and those in the know but stops short of being open about the real agenda by hiding behind a universally accepted therapeutic principle.
(Executive Summary page viii or 10 of 138) "Same-sex sexual attractions, behavior, and orientations per se are normal and **positive** variants of human sexuality—in other words, they do not indicate either mental or developmental disorders." The report provides no scientific data that same sex attractions, behavior, or orientations are positive so in this regard it is deceptive.

(Executive Summary or page viii or 10 of 138) "Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to

heterosexual relationships and families in **essential respects**." The statement is deceptive since scientific evidence is clear that these relationships are anything but stable or committed when considered as a whole.

(page ii or 4 of 138) "APA reports synthesize current psychological knowledge in a given area and may offer recommendations for future action. They do not constitute APA policy or commit APA to the activities described therein." This nice disclaimer I suppose relieves the APA from any liability associated with publishing this report. Should any suite be entered in regards to the report one of the settlement stipulations should be that this disclaimer be included with any published mention of APA's stance on this area whether in print, visual, or aural media much like the Surgeon's general warning on cigarette packs.

(page v or 7 of 138) "Thus, the appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome." The task force moves closer to limiting their definition of what affirmative therapy is including opening the door to the fact that a client may choose and a therapist may support changing the client's sexual orientation identity as long as this is not a predetermined outcome for therapy on the part of the therapist.

(page viii or 10 of 138) "These studies show that enduring change to an individual's sexual orientation is uncommon." The task force admits that enduring change in sexual orientation in an individual is possible through psychotherapeutic efforts. (This is a good Public Relations bullet point)

(page viii or 10 of 138) "The review covered the peer-reviewed journal articles in English from 1960 to 2007 and included 83 studies." Useful studies appear prior to 1960 and Jones and Yarhouse study which addressed the task force's concerns appears after 2007. Why were these particular dates chosen if not to exclude relevant data?

(page ix or 11 of 138)"Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same sex attractions or increase other-sex sexual attractions through SOCE." No references support this conclusion. What specific scientifically valid research indicates that individuals will not be able to change their attractions?

(page ix or 11 of 138) "recent SOCE research cannot provide conclusions regarding efficacy or safety." The task force acknowledges that recent SOCE cannot be scientifically proven to be harmful to a significant number of individuals.

(page x or 12 of 138) "There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation." The task force believes that providing therapy for children and adolescents will not impact their eventual sexual orientation so at best it won't harm them in any way and at worst it will be a waste of time and money.

(page x or 12 of 138) "We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents. "
The task force provides no scientific study to document its concerns in this regard.

(page xi or 13 of 138) "The treatment does not differ, although the outcome of the client's pathway to a sexual orientation identity does." The task force acknowledges that good therapy may result in various outcomes for sexual orientation in individuals seeking change including a gay identity, a bisexual identity, or a heterosexual identity decided on by the client and one does not take any preeminence over the other.

(page xi or 13 of 138) "Other potential targets of treatment are emotional adjustment, including shame and self-stigma, and personal beliefs, values, and norms." The task force believes that personal religious beliefs, religious values, and societal norms are legitimate targets for therapeutic change interventions.

(page xi or 13 of 138) "For instance, The clinical literature stresses interventions that ….reduce internalized sexual stigma." But the literature does not scientifically validate that such interventions are beneficial for the long term health of the client. Most of the literature stressing comes from gay affirmative literature and is conjectural in nature not scientifically validated.

(page xi or 13 of 138) "Additionally, the research and clinical literature **indicates** that increasing social support for sexual minority children and youth by intervening in schools and communities to increase their acceptance and safety is important." There are no scientifically validated studies that support this premise.

(page xi or 13 of 138) "The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation." The task force acknowledges that therapists should respect the importance and significance that faith holds for some clients.

(page xi or 13 of 138) Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives; increase positive religious coping; foster an understanding of religious motivations; help integrate religious and sexual orientation identities; and reframe sexual orientation identities to reduce self-

stigma." The task force believes that therapists should figure out a way to reinterpret the revelation and teaching of the bible so that same sex attracted individuals can feel good about practicing a gay identity, remaining celibate, or claiming a heterosexual identity? To accomplish this requires some very complicated twisting of the truth presented in the bible.

(page xi or 13 of 138) "Licensed mental health providers strive to provide interventions that are consistent with current ethical standards. The APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) are resources for psychologists, especially Ethical Principles B (Benefit and Harm), D (Justice), and E (Respect for People's Rights and Dignity, including self-determination). For instance, LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, **such as the evidence provided in this report** (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgment)." This statement elevates the report to the level of an ethical imperative something the task force specifically indicated in the verbal presentation at the APA meeting was not allowed by the APA where they said that they were not permitted to judge on ethical issues by the division of APA which normally sets APA ethical policy.

(page xi or 13 of 138) "LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status." This statement is useful for publicity since it indicates that religion must be given at least equal status with sexual orientation. It is interesting I am told that the Division 44 public meetings at the APA meeting with signs about diversity excluded religion in this list.

(page xi & xii or 13 & 14 of 138) Self-determination is the process by which a person controls or determines the course of her or his own life (according to the *Oxford American Dictionary*). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. This suggest the possibility of a cause of action against any therapist that automatically uses a gay affirmative approach on a client who is unsure of how to proceed with their same sex attractions and has not yet decided that moving to a gay identity is the goal they would like to pursue. There have been recent reports of therapists being brought before professional bodies with actions against their license by clients who were gay activist in secret bating their therapists to use reparative therapy and then claiming harm. Nothing is to prevent a same sex attracted client with strong religious beliefs

from going to a notorious gay affirmative therapist and asking help with reconciling their religious beliefs and their same sex attraction. When the therapist launches into gay affirmative therapy without being assured that this is what the client desires a similar cause of action would seem open for the client with legal help to move against the therapists license using the task force report as evidence that the therapist was predetermining the goals of therapy. From a publicity standpoint it makes sense to announce to the world that therapists should not push a gay affirmative agenda on same sex religiously conflicted clients and this is supported by the APA task force report.

(page xii or 14 of 138) "Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has not provided evidence of efficacy, has the potential to be harmful, and
delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. This is a largely nonsense statement since any new therapy is going to first have isolated reports of success before sufficient evidence has accumulated to prove efficacy and will carry the potential for being harmful until sufficient evidence accumulates to show that it is no more harmful than anything else therapists do. In what sense SOCE delegates diagnosis and type of therapy I cannot understand and the statement carries the implication that somehow therapists who practice SOCE are not qualified or possess no expertise.

(page xii or 14 of 138) "Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; and (e) include measures capable of assessing harm." This presents the ideal for research but an impossible goal. One cannot generalize a population of individuals seeking SOCE nor address in a controlled fashion all preexisting and co-occurring conditions, mental health problems, other interventions and life histories so that progress in change is not confounded in some measure by them.

(page 8 or 16 of 138) In general this discribes the process of forming the committee and suggest that it was open to the most qualified people but a verbal exchange between Douglas Haldeman at the presentation of the Task Force report at the APA convention confirmed that the selection of the task force was anything but open and that oppositional viewpoints were systematically excluded. The task force said nothing in response to Dr. Haldeman's conjectures to discredit his characterization of the selection process thus giving tacit approval that it was correct.

(page 11 or 19 of 138) "3 We use the adjective *normal* to denote both the absence of a mental
disorder and the presence of a positive and healthy outcome of human development." Prostate cancer is normal for older men but certainly can't be considered positive, same sex attraction is neither "normal" or "positive" it has an unusual or rare incidence in the population and is still considered unfortunate by the majority of the population.

(page 14 or 22 of 138) "(d) lesbians, gay men, and bisexual people can live satisfying lives and form stable, committed relationships and families that are equivalent to heterosexuals' relationships and families in essential respects (APA, 2005c; Kurdek, 2001, 2003, 2004; Peplau & Fingerhut, 2007)." It would be interesting to see if the methodology applied to the scientific studies which support this conclusion are as rigorous as those that conclude sexual orientation does not change. I haven't had time to read these studies but I would assume they generalize a few positive experiences in isolated cases to concluding that the same is true of the whole gay population. Although heterosexual couples currently are not in a good place I doubt that gay couples by any measure could be considered to be in an equal or better place. This is like saying that 1% of gay couples can live better than 20 % of heterosexual couples. It is a meaningless and deceptive comparison.

(page 14 or 22 of 138) "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." This is a good publicity sound bite for our side in that we can say the APA task force acknowledges that sexual identity is fluid and can change.

(page 14 or 22 of 138) "EST are interventions for individuals with specific disorders that have been demonstrated as effective through rigorously controlled trials (Levant & Hasan, 2009).... We were not able to identify affirmative EST for this population (cf. Martell, Safran, & Prince, 2004). Could one ethically select from a population of individuals dissatisfied with their sexual orientation on religious grounds and assign one group to reparative therapy and the other group to gay affirmative therapy? Could one ethically select between individuals who dissatisfied with their sexual orientation apart from religious reasons and assign one group to reparative therapy and the other to gay affirmative therapy? Both propositions would violate client autonomy by forcing some religious individuals to go against their religious beliefs and some gay clients client autonomy would be violated by attempting to change their sexual orientation against their will. No EST trails as proposed will ever be performed as they are impossible to do.

(page 15 or 23 of 138) "We acknowledge that the model presented in this report would benefit from rigorous evaluation." This also makes good publicity in that the task force admits that its model for therapy is conjectural and need scientific support.

(page 18 or 26 of 138) "16 These conflicts are not unique to religious individuals but are applicable to individuals making commitments and decisions about how to live according to specific ethics and ideals (cf. Baumeister & Exline, 2000; Diener, 2000; Richards & Bergin, 2005; Schwartz, 2000)." A good publicity point the task force acknowledges that some individuals come to dislike their orientation apart from religious reasons.

(page 19 or 27 of 138) "The resolution affirms APA's position that prejudices directed at individuals because of their religious beliefs and prejudices derived from or justified by religion are harmful to individuals, society, and international relations." Another publicity point the Task force acknowledges that religious beliefs in regards to homosexuality must be respected.

(page 23 or 31 of 138) "Studies failed to support theories that regarded family dynamics, gender
identity, or trauma as factors in the development of sexual orientation (e.g., Bell, Weinberg, &
Hammersmith, 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord, McCord, & Thurber, 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes, Ferguson, & Gillem, 1976)." I would like to review these studies. Were they subjected to the same scientific methodological rigor as those supporting change in sexual orientation?

Strong Recommendations by the APA Made in the Absence of "Adequate" Evidence.

David Wood, Ph.D.

If the authors' conclusions regarding the inadequacy of evidence regarding the efficacy of sexual orientation change efforts are accepted, on what basis should the resulting recommendations be accepted? The normal course of action when inadequate evidence is available is to call for additional research and to refrain from making strong conclusions. This trend of making assertive recommendations in the absence of adequate data is applied to the evidence of harm as well as the issue of efficacy of those efforts. Evidence of harm is not strongly evident in the research reviewed and any conclusion that SOCE uniformly or highly likely to result in harm is unfounded. This is particularly problematic in light of the Report's discussion of the perceived benefits and satisfaction with SOCE among some participants.

Differential regard for recent key studies on sexual orientation change efforts.

Two very important recent studies (Jones & Yarhouse, 2007; Spitzer, 2003) are treated only in a very cursory manner in the Report. Each of these studies appears to be utilized as a source of data regarding SOCE participant experiences as long as the experiences had nothing to do with sexual orientation change.

For instance, given the importance and methodological improvements of the Jones and Yarhouse study over some previous research efforts, it seems inadequate and even odd that the Task Force categorized it as inadequate alongside other studies with less rigor. Aside from some general reasons for exclusion listed in a footnote on page 90, the dismissive regard for this particular study seems particularly conspicuous in light of the study's prospective methodology. Of the approximately 16 references to Jones and Yarhouse (2003), the majority report participant experiences as long as the experienced had little or nothing to do with the participants' experience of sexual orientation change. The results of this particular study having to do with sexual orientation change were categorically dismissed.

Another instance of this differential regard of results reported is Spitzer (2003). Of the approximately 19 references to this study, descriptions of the sample predominated the discussion. Any mention of change was carefully worded as "perceived changes." The implicit effect is to suggest that participant perception of change reported in this study is to be categorically disregarded rather than carefully scrutinized for the strength and liabilities inherent in the study's design and results.

The general disdain of research on sexual-orientation change efforts.

An important part of the critique offered by the Report is that much of the literature on SOCE tends to appear in publications that are deemed of lesser credibility and influence. The implication is that the published literature suffers from poor methodological rigor and that this is the essential reason why these studies do not appear in the top-tier journals. What the Report author's fail to acknowledge is the strong bias and pervasive reluctance of journal editors to accept manuscripts on the topic unwanted same-sex sexual attraction or SOCE. Much of this reluctance appears to be fueled by fear or reprisals or negative "career repercussions" and "likely fallout" if one is to accept and publish studies in this controversial area (Jones and Yarhouse, 2003, pp 13-14). This reluctance is very real and potently results in few options for publication for studies in this area. The insistence that methodological rigor is the main reason why sexual orientation change studies appear in second tier or gray literature is incomplete and fails to recognize these biases.

APA Task Force Report -- a Mockery of Science

By Joseph Nicolosi, Ph.D.

The American Psychological Association (APA) has just released its "Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation" (August 2009), a report issued by five psychologists and one psychiatrist who are all activists in gay causes.

Remarkably, the APA rejected, for membership on this committee, every practitioner of sexual-reorientation therapy who applied for inclusion.

The rejected applicants included--

- NARTH Past-President A. Dean Byrd, Ph.D., M.P.H., M.B.A., a distinguished professor at the University of Utah School of Medicine, longtime practitioner of reorientation therapy, and co-author of several peer-reviewed journal articles studying change of sexual orientation. Dr. Byrd is considered one of the foremost experts on same-sex attraction and reorientation therapy. He has published numerous articles on sexual reorientation, as well as gender and parenting issues.

- George Rekers, Ph.D., Professor of Neuropsychiatry and Behavioral Science at the University of South Carolina, editor of the *Handbook of Child and Adolescent Sexual Problems*, a National Institute of Mental Health grant recipient, author of the book *Growing Up Straight*, as well as numerous peer-reviewed articles on gender-identity issues*;*

- Stanton Jones, Ph.D., Provost and Dean of the Graduate School and Professor of Psychology at Wheaton College, Illinois, the co-author of *Homosexuality: The Use Of Scientific Research In The Church's Moral Debate.*

- Joseph Nicolosi, Ph.D. (author of this article), a founder of NARTH, practitioner of reparative therapy for 25 years, and author of *Reparative Therapy of Male Homosexuality* and the 2009 book, *Shame and Attachment Loss*.

- Mark A. Yarhouse, Ph.D.**,** is Professor of Psychology, Doctoral Program in Clinical Psychology at Regent University in Virginia Beach, Virginia. Dr. Yarhouse is co-author of *Homosexuality: The Use Of Scientific Research In The Church's Moral Debate* and has published many peer-reviewed articles on homosexuality.

When Clinton Anderson, Chairperson of the Task Force was confronted at an APA Town Hall Meeting as to why the above names were rejected, Dr. Anderson said: "they were not rejected, they just were not accepted."

All of these highly qualified candidates were rejected. Instead, the following individuals were appointed:

Chair: Judith M. Glassgold, Psy.D. She sits on the board of the *Journal of Gay and Lesbian Psychotherapy* and is past president of APA's Gay and Lesbian Division 44.

Jack Drescher, M.D., well-known as a gay-activist psychiatrist, serves on the *Journal of Gay and Lesbian Psychotherapy* and is one of the most vocal opponents of reparative therapy.

A. Lee Beckstead, Ph.D., is a counseling psychologist who counsels LBBT-oriented clients from traditional religious backgrounds. He is a staff associate at the University of Utah's Counseling Center and although he believes reorientation therapy can sometimes be helpful, he has expressed strong skepticism, and has urged the Mormon Church to revise its policy on homosexuality and instead, affirm church members who believe homosexuality reflects their true identity.

Beverly Greene, Ph.D., ABPP, was the founding co-editor of the APA Division 44 (gay and lesbian division) series, *Psychological Perspectives on Lesbian, Gay, and Bisexual Issues.*

Robin Lin Miller, Ph.D., is a community psychologist and associate professor at Michigan State University. From 1990-1995, she worked for the Gay Men's Health Crisis in New York City and has written for gay publications.

Roger L. Worthington, Ph.D., is the interim Chief Diversity Officer at the University of Missouri-Columbia. In 2001 he was awarded the "2001 Catalyst Award," from the LGBT Resource Center , University of Missouri , Columbia , for "speaking up and out and often regarding LGBT issues." He co-authored "Becoming an LGBT-Affirmative Career Advisor: Guidelines for Faculty, Staff, and Administrators" for the National Consortium of Directors of Lesbian Gay Bisexual and Transgender Resources in Higher Education.

Why a Gay Identity Obstructs Objectivity

The fact that the Task Force was composed entirely of activists in gay causes, most of whom are also personally gay, goes a long way toward explaining their failure to be scientifically objective.

To be "gay-identified" means to have undergone a counter-cultural rite of passage. According to the coming-out literature, when a person accepts and integrates a gay identity, he must give up the hope of ever changing his feelings and fantasies. The process is as follows: the adolescent discovers his same-sex attraction; this causes him confusion, shame and guilt. He desperately hopes that he will somehow become straight so that he will fit in with his friends and family. However, he eventually comes to believe that he is gay, and in fact can never be otherwise. Therefore, he must accept his homosexuality in the face of social rejection, and find pride in his homoerotic desires as something good, desirable, natural, and (if he is a person of faith) a gift from his creator.

The majority of the Task Force members clearly underwent this same process of abandoning the hope that they could diminish their homosexuality and develop their heterosexual potential. Coming to the Task Force from this perspective, they would be strongly invested in discouraging others from having the opportunity to change -- i.e., "*If it did not work for me, then it cannot work for you."*

Conducting the Task Force Study

As the basis of their report, the Task Force members say they reviewed several hundred studies which, over the past century, have found subjects who changed their sexual orientation from homosexual to heterosexual.

The published and peer-reviewed studies they considered are all in some way flawed, the committee concluded, and therefore constitute "insufficient evidence" of the possibility of change. As a result, psychologists are advised to avoid telling their clients they can change their feelings. (The committee does grant, however, that some people can and do change their sexual identity—their sense of "who they are"--and go on to live heterosexually functional lives.)

How could the committee have reached a conclusion that would so sweepingly dismiss decades of research evidence? Some of it was conducted by well-known and highly prestigious professsionals, such as Irving Bieber, Charles Socarides, Houston MacIntosh, and Robert Spitzer-- the same psychiatrist who oversaw the removal of homosexuality in 1973 from the diagnostic manual.

It was Dr. Spitzer who concluded in his recent report (published thirty years later by a prestigious journal – the *Archives of Sexual Behavior,* Vol. 32, No. 5, October 2003, pp. 403-417):

> "Many patients, provided with informed consent about the possibility that they will be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions."

He adds, "[T]he ability to make such a choice should be considered fundamental to client autonomy and self-determination."

Lack of Diversity Among Task Force Members

If the APA truly wished to study sexual orientation, they would have followed established scientific practice by choosing a balanced committee that included individuals with differing values and worldviews. Particularly, they would have selected clinicians who see the value of sexual-reorientation -- not just such therapy's philosophical opponents.

Instead, they 'turned the henhouse over to the foxes" by selecting gay-activists members who are well-known for their disapproval of efforts on the part of other homosexual individuals to seek change. The committee prefaces their report by stating as "scientific fact" their view – which has not been scientifically demonstrated (and, which is as much a question of philosophy as of science) that homosexual attractions and behavior are no different from heterosexuality.

Why did the APA select *only* such individuals? Perhaps, in well-meaning ignorance, they thought only gay activists could be experts on homosexuality. Perhaps they were intimidated by the threat of "homophobia" if they invited reorientation therapists to participate.

The scientific bias of the Task Force is further evidenced by four facts:

- The Task Force failed to reveal the well-documented, far-higher level of pathology associated with a homosexual lifestyle. If they had truly been interested in science, they would have believed it their duty to warn the public about the psychological and medical health risks associated with homosexual and bisexual behavior. Their failure to advise the public about the risks not only betrays their lack of commitment to science, but prevents sexually confused young people from accurately assessing the choices available to them.

- Why do some people become homosexual? The reader of the Report might justifiably expect some discussion of the factors associated with the development of same-sex attractions. Instead, the Task Force failed to study the risk factors—instead, saying that it is a "scientific fact" that homosexuality is "as developmentally normal as heterosexuality."

- The Task Force did not study individuals who reported treatment success. Even if (for the sake of argument) therapeutic change had been reported to be successful in *only one* case, then the committee should have asked, "What therapeutic methods brought about this change?" But since the Task Force considered change unnecessary and undesirable, they showed no interest in pursuing this avenue of investigation.

- The Task Force's standard for successful treatment for unwanted homosexuality was far higher than that for any other psychological condition. What if they had studied treatment success for narcissism, borderline personality disorder, or alcohol/food/drug abuse? All of these conditions, like unwanted homosexuality, cannot be expected to resolve totally, and necessitate some degree of lifelong struggle. Many of these conditions are, in fact, notoriously resistant to treatment. Yet there is no debate about the usefulness of treatment for these conditions: psychologists continue to treat them, despite their uncertain outcomes.

Different Concepts of Wholeness

The Task Force moved on to address religious beliefs that conflict with the affirmation of homosexuality. They attempt to resolve this conflict through creating a false distinction.

Organismic Congruence. Their report says, "Affirmative and multicultural models of LGB psychology give priority to organismic congruence (i.e., living with a sense of wholeness in one's experiential self)" (p. 18).

Telic Congruence. This applies to people of faith who do not wish to integrate their homosexuality; they are instead "living consistently within one's valuative goals."

This is a half-truth, and a deceptive distinction. It implies that persons striving to live a life consistent with their religious values must deny their true sexual selves. They will not experience organismic wholeness, self-awareness and mature development of their identity. These attributes are only possible, by their definition, for individuals who embrace, rather than reject, their same-sex attractions. Religious individuals seeking "valuative congruence" are assumed to experience instead a constriction of their true selves through a religiously imposed behavioral control.

This erroneous distinction (one that can only be made by persons who have never known the harmonious integration of religious teachings) misunderstands and offends persons belonging to traditional faiths.

Rather, the members of the Task Force need to understand that the person of traditional faith finds his biblically based values to be guides, signposts, and sources of inspiration that will guide him on his journey toward wholeness. He intuitively senses that they lead him toward *a rightly-gendered wholeness* which allows him to live his life in a manner congruent with his creator's design.

This wholeness is satisfying, experiential, and deeply integrated into the person's being. It is achieved not by suppression, repression or denial--but by understanding homosexuality within the greater context of a mature religious wisdom that is integrated into a scientifically accurate psychology.

An Analysis of: American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.

James E. Phelan, APA Member

Summary: After a careful review of the 2009 *APA Task Force's Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, several critical items have been noted and are provided here. In general, the task force has stated, and the APA has voted on a resolution that sexual orientation change efforts (SOCE) is not likely to change sexual orientation, and that the continued use of SOCE is inappropriate and cautions its use in the marketplace. They justify such statements based on the task force's review of a limited body literature which they have judged as poorly designed, with serious methodological problems. As a result, the original task force document has been peer reviewed by this APA author, and is found to contain serious problems, mostly dealing with bias and misrepresentations of the research, which has ethical, legal, and public health implications. Finally, while the task force suggests SOCE unlikely produces change in sexual orientation and can even be harmful evidence, their own review of the research reveals there is not sufficient evidence to say whether or not harm is a result of SOCE, or that sexual orientation can or can not be changed. So, for them to make public policy recommendations, based on evidence that is not definitive,

presents a serious problem to both the public and mental health profession. A call for legal review is warranted due to APA's bias, misleading the public, abuse of authority, and for having a direct barring impact on clients' rights to self-determination and choices of services in the free and open market place in the United States of America.

The American Psychological Association (APA), a USA-based organization with approximately 150,000 members, via a hand-picked 6-member committee by then APA President, Dr. Sharon Stephens Brehm, titled, *APA Task Force on Appropriate Therapeutic responses to Sexual Orientation* reviewed 83 articles[1] dealing with sexual orientation change efforts (SOCE) in English from 1960 to 2007, with most studies conducted before 1978. The report with proposed resolutions was released during the APA's 2009 annual convention in Toronto in a document titled *Report of the American Psychological Association Task Force on Appropriate Therapeutic responses to Sexual Orientation*. As a result, the task force resolutions were adopted by the APA's governing council. The following are several highlights of an analysis of the task force report (APA, 2009), resolutions (APA, 2009, Appendix A) and/or news release (APA Press Release, 2009):

1. A major problem of the aforementioned report was the task force authors (chosen by the APA in 2007), who were partisan agents with a clear objective. That was to dismiss SOCE and recommend policy against its further use. Prior to any charged research review, the appointed task force chair had already made her conclusions. This chair, Dr Judith M. Glassgold, was not an advocate of SOCE, in fact was a longstanding gay and lesbian activist, and knew very well of the criticisms of SOCE. This was clear by her earlier prolific published works and presentations. Along with other gay advocates, in a 2002 letter to the editor of the APA journal *Psychotherapy*, she stated, "…the literature advocating reorientation therapies has been criticized in numerous ways…" (Glassgold, Fitzgerald, & Haldeman, 2002, p. 376). However, at that time she said these criticisms "need to be addressed thoroughly by advocates of such therapies" (p. 376). But, when such persons applied to be part of the task force, they were not chosen. If Glassgold was sincere in her notion to have advocates address any criticisms or research flaws, she did not follow through with it. If the task force was to be fair, it would have been

1. See bullet #29.

bipartisan as well as balanced out with neutral agents. Instead, it was totally comprised of opponents of SOCE, even prior to the systemic review, the review for which they made their case to recommend SOCE not be used, and subsequent recommendation for public policy (Appendix A), and to be used by mental health organizations world wide (p. 89). The report is not a minor opinion piece; it was meant for worldwide distribution built with authority from the largest American organization of psychologists. As such, its' corresponding press release to the Associated Press (the largest media outsource available) disseminated the information from the report, thus sparking leading major newspapers world wide to headline their conclusions.

2. In their findings, the task force alleged few studies on SOCE could be considered methodologically sound. However, "few studies" do not support a case to dismiss further use of such efforts as they suggested in their report and recent press release (APA, Press Release, 2009).

3. They said no study systematically evaluated potential harm. Therefore, it can not be said that SOCE is harmful in general.

4. The authors stated that, "The entire population of people who seek SOCE is unknown because the studies have relied entirely on convenience samples" (p. 3). If the population was largely unknown then it seems premature to issue a press release which told mental health workers they should avoid telling clients that they can change their sexual orientation through therapy or other treatments.

5. The authors noted that, "…some [former participants in SOCE] perceived that they had benefited from SOCE …" (p.3), and "…some [former participants in SOCE] perceived that they had been harmed [from SOCE]" (p.3). Therefore, there's no consensus. In addition, they admit the research was not adequate to determine these factors to begin with. However, they showed bias in their discussions. For example, they highlighted, "there is some evidence that such efforts [SOCE] cause harm" (p. 66), but then on the item of *benefit* they said, "We have found limited research evidence of benefits from SOCE" (p. 68).

6. They stated that because the research on SOCE had not adequately distinguish between *sexual orientation* and *sexual orientation identity* such research has obscured what actually can or cannot change in human

sexuality (p. 3). If they do not know what can or cannot change, then why did they issue a press release which told mental health workers they should avoid telling clients that they can change their sexual orientation through therapy or other treatments? Why, in their report did they say, "sexual orientation identity –not sexual orientation-appears to change via psychotherapy, support groups, and life events" (p. 63)? These are critical questions the task force must address.

7. In one part of the report the author's say, "Sexual orientation is a complex human characteristic involving attractions, behaviors, emotions, and identity" (p. 29). However, in another part of the report they dichotomized *sexual identity* and *orientation*. S*exual identity* was defined as a person's individual or group membership and affiliation, self-labeling, sexual values and behaviors. *Sexual orientation* was defined "as an individual's pattern of erotic, sexual, romantic and affectional arousal and desire for other persons on those person's gender and sex characteristics" (p. 11). They concluded that it is unlikely that one could change *orientation*, that changes occur only in *identity*; however, this neglected reports in the literature, and it differs from other definitions of *sexual orientation*, for example, *sexual orientation* according to Flarlex Dictionary, is defined unitarily by, "The direction of one's sexual interest toward members of the same, opposite, or both sexes". Therefore, with this definition, if one changes their "sexual interest", they have changed their *sexual orientation.* Above all this is the fact that the task force defined *sexual orientation*, either pre or post-review. It certainly was not clear, nor based on the review itself considering they alleged the studies reviewed were flawed due to construct validity (p. 29). In other words, the researchers neglected to adequately define, and subsequently, measure *sexual orientation.* Therefore, they constructed their own definition to satisfy their own agenda. This is not an appropriate action.

8. The authors said that, "Given this new understanding of sexual orientation and sexual orientation identity, a great deal of debate surrounds the question of how best to assess sexual orientation in research" (p. 30). In an attempt to valid this statement they cited reports dated: 1948, 1953, 1979, 1995 and 1997. These dates do not indicate a period of "new understanding" considering that the last citation was over 12 year ago.

9. While the task force stated that few forms of SOCE have not been subjected to "rigorous examination of efficacy and safety (p. 83), such

comment could be made for other widely used types of psychotherapy, including Gay Affirmative Therapy (GAT). While the APA may support GAT or other affirmative processes, they too have not been subjected to rigorous study to evidence scientific efficacy.

10. Although they tell practitioners to not aim to alter sexual orientation, they tell researchers that since the research on SOCE, "has not adequately assessed efficacy and safety" (p. 6), that research on SOCE can go forward as long as it is done with "high-quality measures" (p. 6). This, therefore, takes the assumption that SOCE shall take place regardless of their position.

11. The task forces' definition of *sexual orientation* is not the only problem surrounding definitions in the report. For example, *sexual minority* is a term they used to describe "the entire group of individuals who experience significant erotic and romantic attractions to *adult members* of their own sex…" (p. 1, emphasis added), yet they describe youth and adolescents as "sexual minorities". This is confusing since by their definition, the attractions of such "sexual minorities" are to members of one's own sex who are "adults".

12. The report mentions *minority stress* and *sexual stigma* (p. 1) and claims that there is a "growing body of evidence concluding that sexual stigma" (p.1) directed at non-heterosexuals is responsible (see also p. 54). However, a recent study was conducted in an effort to find out what mechanisms (e.g. *minority stress*, environmental factors, genetic factors) might likely elevate psychiatric vulnerabilities of nonheterosexuals (admitting the latter has been the case). In conducting their literature review, they found some support for a "minority stress" hypothesis however such support was weakened by the fact that the relationship between sexual orientation and mental health is strong even in liberal countries, such as the Netherlands (Zietsch et al, 2009).

13. The authors believe that *sexual minorities* benefit when they are taught to "overcome negative attitudes about themselves" (p. 13). The best form of treatment they feel is *gay-affirmative therapeutic interventions* (p. 13). This *sexual orientation stigma* or *internalized homophobia* is said to be a result of societal prejudices and discriminations. They argue that homosexuality is stigmatized (p. 14). There, they cite 2 reports by the same authors. In the report, the authors claim that one of the factors that

may lead on to SOCE is internalized stigma, however they go on to say "clients' motivation to seek out and participate in SOCE seem to be complex" (p. 45), so therefore no real definitive statement can be made because they are admittedly not clear why. But, at ay rate, they make this rapid claim.

14. The report alleged that the studies reviewed showed "enduring changes to the individual's sexual orientation [was] uncommon" (p. 2), and "unlikely" (p. 63) however they stated that the majority of the studies were not longitudinal studies. If the studies were not longitudinal, then it could not be concluded that enduring changes were uncommon. Instead of saying they were not uncommon in the general sense they should have said they were not studied in the larger sense.

15. The task force admitted that the field of psychoanalysis (along with behavior therapy) was most associated with the published literature on SOCE; psychoanalytic literature was published chiefly during the 1950s and 1960s (p. 11). They admitted that homosexuality treatment up until the first half of the 20th century was psychoanalytic in nature and "the dominate psychiatric paradigm" (p. 21) of that time. The current APA task Force however did not review and include this whole body of literature in their report. Rather, they created just one short paragraph titled "homosexuality and psychoanalysis" (p. 21) which largely discussed theory (which they dismissed as heterosexist) and not therapy. It shows bias on part of the authors to exclude reviews of psychoanalytic reports, especially the Bieber et al. (1962) study of patients who received treatment, and at the time, produced a methodological design which held quality research standards. In fact, at the time, it was the largest study available; however, the task force did not even include it in their systematic review of other older studies.

16. Rationales given for developing the new task force report: (a) "some APA members" believed the 1997 resolution needed to be revaluated, mainly because it did not address questions of efficacy or safety of SOCE (p. 12). However, they never mention who these members were, how many, and in what format they addressed concerns; (b) "highly publicized research reports" of samples of individuals who had attempted sexual oriented changes were published and "other empirical and theoretical advances in the understanding of sexual orientation were published". However, of the papers cited, only one of the former would be considered highly publicized

(Spitzer (2003)), and of the latter, a third of what was cited was published **after** the task force was formed; (c) Advocated asked for it. One named was "Truth Wins Out" which is solo operation, headed by a nonclinician, Mr. Wayne Besen who is known for being a gay-identified radical, who runs a blog which allows for derogatory language and sexual content, not suitable for youth (one population the APA feels it wants to benefit by the task forces' report), and definitely not scientific.

17. The authors cite 2 pieces (American Psychiatric Assoc, 1973, and Gonsiorek, 1991) as evidence that "**same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality and are not indicators of either mental or developmental disorders**" (p. 14). These 2 reports are inadequate to be held as a basis for such disclaimer. The former, is not a scientific study, rather a statement. The latter was from a chapter in a book, for which the book chapter's author admitted the research was taken from faulty samples and poor designs. Besides, scholars have exclaimed, in a peer-reviewed research project on systemic review of research, that book chapters are not good evidence as they "…tend to not be peer-reviewed but rather invited" (Serovich, et al 2008, p. 229). Finally, in conducting their own systematic review of the research on SOCE, the authors of the current report, excluded studies that were not published in the format of a peer-reviewed scientific journal (p. 26).

18. The authors claim *minority stress*, political opposition, and interpretations of traditional religious doctrines "…guide some efforts to change other's to change their sexual orientation…" (p. 17). However, this shows bias as they only include external factors of client's motivations, neglecting possible internal motivators, client's self-determination, and autonomy.

19. As a point of note, the authors acknowledge that "difficulties arise because the psychological community considers same-sex sexual attractions and behaviors to be a positive variant of human sexuality, while some traditional faiths continue to consider it a sin, moral failing, or disorder that needs to be changed" (p. 18). This is also considered a "conflict" (p. 18) and when it arises the authors admit "quite complex" (p. 69).

20. In their discussion of psychology, religion, and homosexuality, the authors discuss two philosophical concepts: *telic* (living consistently within one's valuative goals) and *organismic congruence* (living with a sense of

wholeness in one's experiential self). The authors' said, "Affirmative and multicultural models of LGB psychology give priority to organismic congruence" (p. 18). Whereas the *telic* concept would give priority to values (e.g. fundamental beliefs that homosexuality is immoral; disorder that needs to be changed). Although, they acknowledge *telic* concept as valid, and that differences remain (see # 19, above), they clearly demonstrate a favor bias to the *organismic congruence* concept. Also, problematic, and insensitive, is that traditionally religious individuals, with conservative, fundamental-belief systems, seeking valuative (telic) congruence are assumed to experience a constriction of their true selves through religiously imposed behavioral control. However, that disregards change elements experienced by many of these individuals, historically documented.

21. The authors sated that, "…although many religious individuals' desire to live their lives consistently with the values, primarily their religious values [telic congruence], we concluded that [that]…was unlikely to result in psychological well-being" (p. 55). They say this without any formal testing of telic and organismic congruence in the studies of SOCE. This is clear indication of the author's bias.

22. The report highlights clearly that APA views science and religion as separate and distinct. But, "faith does not need confirmation through scientific evidence" (p. 19), they said. The authors go on to say, "Further, science assumes some ideas can be rejected when proven false; faith and religious beliefs cannot be falsified in the eyes of adherents" (p. 19). In the final analysis, they point out that "faith traditions 'have no legitimate place arbitrating behavioral or other sciences'…or to 'adjudicate empirical scientific issues in psychology'" (p. 19). They say that they "take the perspective that religious faith and psychology do not have to be seen as opposed to each other" (p. 20) and there should be an "integrat[ion] (p. 20) of both, yet clearly polarize the two by saying that religious faith has a back of the bus seat to psychology. So, how can they *not* be opposed? This is clearly a two-faced posture.

23. In a section, "Affirmative Approaches" (p. 22), to make their case that the theories that drove earlier SOCE were accumulated by evidence that yielded those theories "ill-founded" (p. 22), they cited three studies. One was the Kinsey Report (1948) which claimed that homosexuality was more "common" than thought. However, speaking of methodological factors,

that was certainly not a golden model. For one, some of the subjects were pedophiles in prisons. The other study cited was Ford and Beach (1951) which suggested that since homosexuality was observed in the animal kingdom it must be natural (See my earlier review of animal homosexuality, Phelan, 1998). And, finally they cite Hooker (1957), who used a small convenience sample, to make a case that homosexuals were no more pathological than heterosexuals, which has lost rigor.

24. They review the history of the removal of "homosexuality" from the DSM (p. 23). This has been critiqued already. They ignored the fact that this removal was for social-political reasons, not scientific. They merely briefly mentioned that it was escalated by the Stonewall riots. This again highlights the authors' bias.

25. The whole basis of the task force report hinged on their review of research evidence of SOCE. However, in the section, "Sexual orientation change efforts provided to religious individuals" (p. 25) they point out that "recent studies" (p. 25) on SOCE included "almost exclusively individuals who [had] strong religious beliefs" (p. 25), included "a highly select[ed] group of people" (p. 28), and "composed almost exclusively of Caucasian males" (p. 33), however they failed to mention that in a sample of studies (1954-2004), 17 of which they reviewed, 82% did not even report the religion of participants and 79% did not report race (Serovich et al., 2008). In fact, Serovich et al (2008) concluded that there were so many omissions of demographics in studies of SOCE, it threatened the validity of interpreting the data.

26. A specific meta-analytic report, published in a peer-reviewed journal was excluded (p. 27), based on their own explanation that it deviated from standard meta-analytic protocol telling the reader to see 2 other reports for reasoning of such. However, one had nothing to do with the specific report, and the other was not even listed in the reference section. The latter a deviation in and of itself.

27. In a footnote to the overview of their systematic review, they say that they excluded one study based on it being published in 2008 (p. 27) after their review was completed *and* that it "appeared" to be a reworking of an earlier study by the same authors. If it "appeared" to be one thing, then this says they reviewed the study, at least in part, clearly showing partiality in its exclusion. If it were solely excluded on the factor of the publication

date, that is one thing, but to say "and", for another reason, it complicates matters. It so happened that the authors of the aforementioned study, as the one mentioned in the bullet above, were proponents of SOCE, so this clearly show the reviewers bias to exclude them. In addition, the authors managed to included other citations as late as 2009 in the writing of their report, so it is doubtful that it was too late to use a 2008 published study.

28. The task force report evidenced some neglect in providing references to citations; a few noted: Byrd, Nicolosi, & Potts (2008); Lipsey & Wilson (2001); McIntosh, 1990; Society for Prevention Research (2005). Without full reference, readers are unable to know what work they are referring to and therefore unable to verify the data. This would seem to have been caught in a rigorous peer-review process and editorial process for which the APA should have been at an advantage to receive.

29. The authors said they reviewed 83 studies, providing an appendix which cites (N=83): (6 experimental, 3 quasi-experimental, 46 non-experimental). However, if you add up what they actually listed (see Appendix B, pp. 125-130), the number only equals 55. Again, if this was rigorously peer-reviewed, the reviewers would have caught such a huge discrepancy.

30. The authors criticize the studies they reviewed on several basis, one being that that treatment samples had high drop out rates. However, other forms of treatments have high drop out rates (e.g. drug and alcohol treatments) yet the APA does not set up a task force to caution its use.

31. The authors claim that "people will report change under circumstances in which they have been led to expect that change will occur…" (p. 29), however they do not provide any evidence to validate this statement.

32. The authors admit that "external validity (generalization) of earlier studies is unclear" (p. 34), however they use these studies as a backdrop for their disclaimer that sexual orientation is not likely to change and that it should not be available in the marketplace.

33. The authors reported that the studies they reviewed provided "some evidence of harm" (p. 35), however the majority of the studies were not conditioned to even measure harm, nor were they systematic or longitudinal for that research item. They seemed to show bias by

embracing this finding when other findings were dismissed under the notion that the studies were not held up "under the rigor of experimentation" (p. 35). Finally, the outcomes they discussed for the studies they reviewed gave blanket statements of random variety of symptoms of client's reports. As the case with any study of treatment, the issues of side effects are never clearly known to be a product of the therapy itself, or due to other factors, since so many other factors occur simultaneously in a patient's life, and could be possible explanations.

34. The authors, independent of the studies findings, defined sexual orientation "as an individual's pattern of erotic, sexual, romantic and affectional arousal and desire for other persons on those person's gender and sex characteristics (p. 29), however, in their systematic review of outcomes, they only reported on the items of *attractions*, *behaviors*, and *harm*. The items of "desire" and "romantic and affectal arousal" (assumed not necessity sexual, e.g. some people can be asexual, or sexually dysfunctional, castrated, etc), were not addressed. So, how can they make a statement that sexual orientation is unlikely to change when evidence has not been evaluated to satisfy their definition?

35. In their section of outcomes of "improving mental health" (p. 41), the authors failed to discussed what recent studies on the subject showed. They only discussed 3 studies from earlier research (1970-1972). This evidenced bias as they did discuss the harm items of recent studies.

36. The authors said, "[studies] provide no clear indication of the prevalence of harmful outcomes among people who have undergone [SOCE]" (p. 42) (this is because they found that no study to date was designed with adequate scientific rigor to measure such), but said that attempts to change "may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts" (p. 42). If no "clear indication" was found, how can they say attempts may cause distress?

37. The authors reported on twelve studies where anecdotal cases of harm was reported and they said, "we found that there was some evidence to indicate that individuals experience harm from SOCE" (p. 43)), but then they reported on at least 55 studies that looked at efficacy outcome of therapy, and where they also found evidence that some patients reduced same-sex attraction and behavior, they choose to discuss those outcomes

as “rare” and that “few studies provided strong evidence” (p. 43). The authors chose to show bias as they did not use the same language applied to SOCE as they did for the item of harm?

38. Participates in some recent studies reported beneficial effects such as a perceived change in their sexual orientation, even if this was distinct from scientific evaluation. The APA stated in their press release that “mental health professionals should avoid telling clients that they can change their sexual orientation through therapy or other treatments” and per other studies it “was unlikely to change”. They go on to say that certain studies suggested that some individuals learned how to ignore or not act on their homosexual attractions. Yet, these studies did not indicate for whom this was possible, how long it lasted or its long-term mental health effects. Also, this result was much less likely to be true for people who started out only attracted to people of the same sex." While they choose to talk about “suggestions” of the latter, they failed to report the former, that being “Participates in some recent studies reported beneficial effects such as a perceived change in their sexual orientation”. This again, shows bias in reporting. Subsequent to their press release, major news papers made bold claims. For example, after receiving the press release, the *Los Angeles Times* headlined “Psychologists say sexual orientation can’t be changes through therapy”. While the APA my not be able to control how the media interprets it’s press release, it does state in their own code of ethics[2] that when their research is misinterpreted or misquoted, they have a responsibility to make attempts to correct the source. It remains to be seen if this has been done. At any rate, the damage is done, as millions of readers already accessed the *Los Angeles Times*, and have been exposed to this data.

39. In the task force report the authors admitted that "empirical supported treatments" are a common dilemma in psychology treatment (not just with homosexuality) and that they really based their recommendations not to use therapies aimed at changing orientation on "evidence-based approaches" (p. 14) available -- "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 14). Actually, the arguments to use evidence-based

[2] According the the APA Code of Ethics: 8.10 Reporting Research Results:
(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.); (b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

approaches is based on "current and best evidences" (p. 15), not science, per say, they added. They admitted they used a "flexible" (p. 15) concept of evidence. So, really they admitted they did not have an empirical bases for their position, just one that was "flexible" to what they wanted to say. So, why did they say studies such as Spitzer (2003) and Jones and Yarhouse (2007) were not "current [and] evidence" and dismiss what reparative therapists (clinical) experts are saying about their practices?

40. They task force allege that there are “*no*…peer-reviewed research that supports theories attributing sexual orientation to family dysfunction or trauma” (p. 54, emphasis added), however this ignores previous nonpartisan examinations of theories which counter such allegations (Fisher & Greenberg, 1977, 1996).

41. The authors presented a framework for affirmative therapeutic interventions which was based on “comprehensive review of the research and *clinical literature*” (p. 55, emphasis added), this again shows bias, because they did not consider clinical literature when making their final analysis about SOCE. For example, at least 34 psychoanalytic reports, of over 500 patients who had undergone SOCE exists which could have been reviewed, but were ignored.

42. If what the authors say, and their charge is taken literally, assessment of clients should see, “…the client’s sexual orientation as part of the whole person and to develop interventions based on all significant variables” (p. 56), if indeed truly inclusive, would include SOCE, should clients desire it. The authors said, assessment could include various elements, one “understanding the specific religious beliefs of the client” (p. 56). For some clients, their religious belief is that God can change anything, this would include sexual orientation. The task force must be held accountable to their charge that awareness of religious issues is “important” (p. 57). After all, they admitted that, "[some] individuals reported that SOCE…helped them live in a manner consistent with their faith" (p.3).

43. In working with clients, the authors said it is “relevant” to use various therapy techniques, one being *dialectical behavior therapy*. However, this therapy also lacks rigorous longitudinal scientific research outcomes, the same reason that SOCE were criticized. This shows the authors’ selective bias against SOCE.

44. The authors assume that those who seek SOCE will inherently suffer loss because what they desire (change in sexual orientation) will “not fit the individual’s predispositions” (p. 58). They say that the desire and actual ability to change is “irreconcilab[le]” (p. 58). They claim this will create the need for emotion-focused strategies to affirm sexual orientation identity. They say therapeutic outcomes include helping clients “com[e] to terms with…impossible selves” (p. 58). This assumes that homosexuality is inborn and therefore not changeable. This goes against the fact that there is no conclusive scientific evidence to say homosexuality is inborn.

45. In their framework for working with adults in affirmative intervention they suggest: “refocus clients on…more self-acceptance (assume to include the homosexuality)…than on their religion’s rejection of [the] homosexuality” (p. 59). They say to explore how to integrate the religion’s values with the client’s “sexuality” (p. 59). For some religions and individuals, this may create conflict, however. But, the task force prefers to focus on affirmation of the sexuality rather than on SOCE, or religious traditions or orders.

46. The task force admits that “participants reported benefits from mutual support groups, both sexual-minority affirming and ex-gay groups” (p. 59). This assumes it would be appropriate to refer to either. However, the task force again shows bias as in a footnote[3] provided only resources for gay affirmative communities’ web links and none for ex-gay groups.

47. The task force report says that “…for clients whose…religi[on]..may…stigmatize their sexual identity…these clients may benefit from considering the alternative frame..[one that is] able to affirm their sexual orientation” (p.60). This was problematic in that it created groups to ask if clients should be told to switch churches. This has been addressed in post-media reports[4], however an addendum is needed. This is also problematic in that it did not define what the possible “stigma” is; is it a religious element that is interpreted as stigmatic, or is it real? Is saying that homosexuality is a sin, or disordered, considered “stigma”? Whether this is real, or perceived, is not defined. Also, the bias is evident

[3] Pg. 59

[4] Throckmorton, W. (2009, Aug 21).

as it shifts the attention only to affirmation of sexual orientation and no other options, one being SOCE.

48. The task force says that one possible outcome of sexual orientation identity exploration (p. 60) is a “heterosexual sexual orientation identity” (p. 61). They also admit that “In some literature on SOCE, religious beliefs and identity are fixed, whereas sexual orientation is considered changeable” (p. 61). Therefore, they should not advice those who want to receive or provide SOCE, or sexual identity therapies, not to. This correlates with the APA code of ethics of respecting the client’s autonomy.

49. The authors stated that, “We encourage LMHP (Licensed Mental Health Professionals) to support clients in determining their own… behavioral expression of sexual orientation. If their *own* determination of *sexual expression* is unprotected anal sex with multiply partners then that should be encouraged? Even in light that research exists that unprotected anal sex with multiple partners is a public health problem? On the other hand, they will not say to encourage clients in determining their “own” *sexual orientation*, **only** *identity*. This again, shows clear bias.

50. The authors say that “research on the impact of heterosexism and traditional gender roles indicates that an individual’s adoption of traditional masculine norms increases sexual self-esteem and negatively affect mental health” (p. 62). They give one citation, from a study consisting of a convenience sample. This is not the same standard (rigorous research protocols) they call for in making their case against SOCE. Again, an illustration of bias.

51. They say that LMHP “address specific issues for religious clients” (p. 64) and this includes “spiritual functioning” (p. 64). However, in traditional faiths, the spirit of change is one aspect of dogma. But, in the report they don’t feel change of orientation is likely. This seems to be a conflict.

52. In a footnote on p. 65 the authors say that “Guidelines and standards for practice are created through a specific process that is outside the purview of the task force” (Footnote, p. 65). However in the conclusion of the same report made recommendation for public policy. The same task force was well aware that this report would be used for the APA to use as such, which was voted on at the same convention the report was released. The policy aspect was poised without scrutiny, as the task force itself was

charged by the APA, membership of task force approved by the APA, and the policy aspect voted on by the APA. This was an inside job, with no objective or independent review.

53. The authors said it is, "inappropriate for psychologists and LMHP to foster or support in clients the expectation that they will change their sexual orientation if they participate in SOCE" (p. 66), and that the greatest level of ethical concern was that such treatments were based on the presupposed notion that same-sex sexual orientation is a disorder or symptom of a disorder. They claim homosexuality is not a disorder based on "consensus" in research and by professionals. However a systemic review was not conducted to prove those ideas. To the contrary, a review of research does show that homosexuals in comparisons to heterosexuals do show greater pathology (Zietsch, 2009).

54. The task force, as well as the APA, assert that recommendations should be made when evidence is availed via research. In term of interventions with children, they say, "there is a lack of published research on SOCE among children" (p. 72), but dismiss psychotherapy in children which may alter adult sexual orientation because they feel sexual orientation does not emerge until puberty and that early childhood gender nonconformity does not necessarily subsequent adult homosexuality. Further, they say that interventions suggested to prevent homosexuality have been presented in non-peer-reviewed literature and conflate stereotypic gender roles, and should be avoided. They admit there is "no empirical research on adolescents who request SOCE" (p. 73), but yet warn not to use it.

55. The authors said that sexual orientation distress in adolescents is likely "in families for whom a religion that views homosexuality as sinful and undesirable is important" (p. 73), however this statement is not based on the rigorous research they call for in other areas. The task force again shows bias. In making a case that adolescents with an LGB identity face exclusion and rejection, they provide case studies as proof (e.g. Case, 2007) (p. 73), however they would not allow use of case studies when reviewing SOCE efficacy.

56. I agree with the task force where they say, that any inpatient admission for a child or adolescent be of the shortest possible duration and reserved for the most serous psychiatric illness. Adolescents should not be coerced into residential programs. Therefore I agree with the task forces

recommendation that "LMHP should thrive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments" (p. 76).

57. The authors recommend that "LMHP support adolescents' exploration of identity by accepting homosexuality and bisexuality as normal and positive variants of human sexual orientation" (p. 76). This is bias, however as it does not offer other alternatives, it merely says that one must accept homosexuality or bisexuality as the norm. (They admit that adolescents are in the mist of developmental processes in which the ultimate outcome is unknown" (p. 77)). In addition, it is not inclusive to those LMHP who do not see "homosexuality and bisexuality as normal and positive variants of human sexual orientation" (p. 76).

58. In the section on appropriate application of affirmative intervention with children and adolescents they recommend that LMHP provide "information and education" (p. 80) to LGB which will support them. As for parents, they "can be provided accurate information about sexual orientation" (p. 87). However, there is no mention that LMHP discuss, and parents be taught, the known dangers associated with the LGB population, in general. Most importantly, the scientific fact that since the inception of AIDS, gay men are at high risk for acquiring this disease. For example, the Centers for Disease Control (CDC) have consistently published evidence that gay men and other men who have sex with men (MSM) have AIDS at a rate much greater than women and non-gay/bi men. For a group so concerned about safety and welfare, this would seem so basic to the foundation of education vital to youth entering a high risk population, however it was totally omitted.

59. At one point in the report they said that information that stressed sexual orientation can be changed was based on "very limited empirical evidence" (p. 74), however they did not say "no evidence", since this would indicate there is some evidence, then it would seem fair to not say it was "inappropriate" (p. 66), for professionals to provide SOCE to those who ask for it.

60. At the same 2009 APA convention where the task force released its report, another report was released - an extended longitudinal study (Jones & Yarhouse, 2009). The authors of that report, noted at a symposium that it was "[the] most rigorous longitudinal methodology ever

applied to [the] question of sexual orientation change and possible resulting harm". The conclusions stated that "the findings of this study would appear to contradict the commonly expressed view if the mental health establishment that sexual orientation is not changeable and that the attempt to change is highly likely to produce harm for those who make such an attempt". Given that this improved on methodology standards for which the task force has been critical of, the Jones and Yarhouse study therefore should be an addendum to the task forces' report. Finally, the report was endorsed by a former APA's president who was part of the symposium.

61. The task force emphasized that "*…there is some evidence that [SOCE] cause harm"* (p. 66), but then admits that "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). When it came to their discussion of the efficacy of SOCE they admitted "there is insufficient evidence that SOCE are efficacious for changing sexual orientation", but yet they make a definitive statement saying it would be "inappropriate" (p. 66) to use it. They said this, when in fact they knew that there was some evidence, although in their words it was "rare" (p. 83) and that "few" (p. 83) studies showed it. What they criticized then was the rigor of the studies, not the outcome. This is clear evidence of their bias, and betrayal of public trust.

62. The use of wording in the report clearly shows that they can not definitively say SOCE does not have efficacy or is harmful, so instead they say: "SOCE is *not likely* to produce its intended outcome" (p. 83, emphasis added) verses "SOCE *does not* produce its intended outcome"; and "can produce harm" (p. 83) verses "does produce harm".

63. The task force felt it okay to "expand beyond the scope of the systemic review" (p. 83) in order to develop an understanding of other areas around SOCE, however, they would not look beyond the scope of the systemic review to reveal the several psychoanalytic case studies that have show successful outcomes of SOCE over a 50 year span. This again, shows their bias.

64. To be honest, the only thing we can determine about one's sexual orientation is what we get subjectively. Some things can be objectively observed in the laboratory such as penile volume in response to sexual

stimulus. Other than that, we have to rely on subjective data. Both clients and clinicians have claimed complete reversals in sexual orientation, that from homosexuality to heterosexuality. This has been documented in the literature. In the current task force report, the authors make an unfounded claim: "Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice" (p. 84). This statement has not been tested scientifically and the studies that have looked at a biological origin of homosexuality are not conclusive. Therefore, this is gross misinformation to the public, and the APA should be charged for such misleading. It is also goes against their own standards of presenting claims that are not backed by science.

65. The authors say that "the low degree of scientific rigor in [SOCE] studies makes any conclusions tentative" (p. 85). If "tentative" then why did they say that "sexual orientation is unlikely to change" (p. 84)? Why not, "we don't know, from our interpretation of the limited research, that sexual orientation, can or can not change; any conclusion is tentative; we will need more research to make any definitive recommendations"?

66. In their summary of the task force report, the authors say "we found that religious individuals with beliefs that homosexuality is sinful and morally unacceptable are prominent in the population that currently undergoes SOCE" (p. 82). They then go on to say, "To respond as well as we could to this population we…recently adopted APA policies on religion and science…" (p. 82). If you look closer, the APA polices on religion and science has boldly stated that *intelligent design* (that which traditional faiths follows) is not scientific and that they only view *evolution* as scientifically valid (APA, 2008). They admit this "clashes" (p. 82) and say, "Psychology as a science and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints" (p. 82). However, they say this, yet they do not accept the religious beliefs at face values, saying that it is not scientific thereof not endorsed, in fact it is backseat to evolutionary theory, and recommend only gay affirmative responses. Therefore, they will not "respect" (p.82) any religion believing that homosexuality is sinful and morally unacceptable. This seems to contradict their statement on respecting different philosophical viewpoints.
However, the APA needs to be open to accepting the fact that some patients not only desire "spiritual healing" (Elkins, Marcus, Rajab, & Durgam, 2005, p. 234), but use it in their treatments for a variety of things

with various outcomes, and the data presented in an APA journal suggested that alternative therapies may play an important role in addition to standard psychotherapy practice (Elkins, et al. 2005). The authors claim that SOCE be avoided because "reports of harm suggest that such treatments can reinforce restricting stereotypes, increase internalized stigma, and limit and client's development" (p. 87). But their citations for such disclaimer is based on limited research for which the same argument exists for which they base their disproval of SOCE on – not longitudinal, flaw methodology, some are opinion pieces, outcome unable to be definitive, etc. Again, this shows bias.

67. I agree with the authors that "…LMHP working with clients seeking SOCE obtain additional knowledge and skills…" (p. 88). This knowledge base should also be inclusive of religion and respect for religion regardless if it is seen as "scientific" or not (this will help "…reduce their potential biases…" (p. 88)), client's autonomy and rights to chose SOCE, and **all** theories of sexual orientation. Again, to reduce "biases" (p. 88).

68. The author's accuse the published literature on SOCE to have made "inappropriate conclusions drawn from data" (p. 90), and go into a discussion about how studies with social implications need to held to high standards due to their potential to influence policymakers and the public, and that misleading information can have serious cost. But, the task force suggests SOCE unlikely produces change in sexual orientation and can even be harmful evidence, however, their own review of the research reveals there is not sufficient evidence to say whether or not harm is a result of SOCE, or that sexual orientation can not be changed. In fact they admit, **"…the research on SOCE…has not answered basic questions of whether or not it is safe or effective and for whom**" (p. 90) and "**There are no studies of adequate rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation**" (p. 120). So, for them to make public policy recommendations, based on evidence that is not definitive, in and of itself presents a serious problem to both the public and the mental health profession. Case in point: Based on their own press release to the Associated Press, the *LA Times* said "Psychologists say sexual orientation can't be changed through therapy" (LA Times, Aug, 5, 2009).

69. I agree with the task force where they say people in the field work together to "…improve our knowledge of sexuality, sexual orientation, and sexual

orientation identity…" (p. 91), and that future research is conducted in improved ways.

70. The APA should listen to some of the task force's own recommendations on pg. 92 and hold them to the same standards that they seek in others – (e.g. don't distort and selectively use data to support your own agendas, disseminate accurate data, etc.).

71. Appendix A: Resolution: They made a recommendation to "resolve" that there is "insufficient evidence" (p. 121) to support the use of SOCE. This was based on their finding that "There are no studies of adequate rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation" (p. 120). However, this is bias, because if they say they can not condone it, based on this finding, they must also say they can not condemn it either. Because the fact is, based on the findings, they don't know either way. So, for them to go one way is clearly bias and unjust to the public.

72. As it turns, 12 resolutions recommended by the task force were approved by the APA. The resolution that says not to distort data and mislead public opinion (p. 122), they have already broken.

73. The APA's verdicts (sexual orientation is not likely to change, and therapy aimed at changed should be discouraged) is not based on proof beyond reasonable doubt and common sense after careful and impartial consideration of all the evidence. For one, they did not consider all the evidence and the evidence they choose to use, was admittedly flawed and inadequate. Additionally, the authors were partial to the case to begin with. This has potential to harm the public.

74. The APA and the APA task force, with its voted resolutions, should go under legal review for civil rights violations, for misleading the media, the public and the mental health arena, and by such actions impeding clients from receiving treatment and helping agents the right to provide treatment according to the clients' wishes and desires.

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NOTE: Any citation listed in the body of this text and not listed in the reference section can be found in American Psychological Association Press Release of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009): http://www.apa.org/releases/therapeutic.html or from this author. Thank you.

Thoughts on the 2009 *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*

By Philip M. Sutton, Ph.D.

1. **Arbitrary dismissal of the importance of evidence provided prior to the past 50 years.**

In drafting its list of criteria for acceptable research designs for evaluating the effectiveness of sexual orientation change efforts (SOCE), the American Psychological Association Task Force (subsequently referred to as APA unless otherwise noted) applies post hoc criteria to discount the credibility of older studies and clinical reports of SOCE, i.e., case and qualitative studies, many with multiple subjects/clients/patients, which were reported in the professional and scientific literature. APA begins its evaluation of the most recent 50 years (i.e., latter half of the 20th century) of scientific efforts to document SOCE's effectiveness while ignoring the prior 75 years of reports, admittedly sparse in the latter 19th and earlier 20th century.

2. **Misrepresentation of the basis for originally removing homosexuality from the DSM II** (cf no. 3 below).

Prior to the 1973 and 1974 actions by the APA's, treatment of SSA was considered normative, effective for some, and- like all psychotherapeutic approaches- not generally harmful. No research showed it to be otherwise. What changed was the perceived and ascribed acceptability of diagnosing and treating homosexuality.

The 1973 and 1974 decisions were based on politics- not science, and certainly not on the conduct of new science which refuted old studies, or existing psychotherapeutic practice. Those who have written about this history, including pro-gay activists admit that no new research showing that homosexuality was a healthier than previously thought or actually could not be changed was used to justify the decision. Yet, these decisions by both APA are cited now as if they were proof for what they asserted.

3. **Undocumented and I think erroneous (fraudulent?) claims to a *scientific basis* for the normality of homosexuality.**

- On page 2, Task Force Report's *Executive Summary* asserts that the following are "*scientific facts*" (I do not quote all):

  * "*Same-sex attractions, behavior, and orientations per se are normal and positive variants of human sexuality-in other words, they do not indicate either mental or developmental disorders* (p. 2, cf. pg. 54)*."*

  *** The first Resolution reads similarly that the APA "*affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity*"; while the second Resolution adds that APA "*reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation*" (pg. 121).

  * *Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects (pg. 2).*

  * *"Affirmative approaches (to treating)…the distress surrounding sexual orientation…are based on* ***the evidence*** *that homosexuality is not a mental illness or disorder, which has* ***significant empirical foundation*** *(APA, 2000: Gonsiorek, 1991)."*

  * *"****There are no empirical studies or peer-reviewed research*** *that support theories attributing same-sex sexual orientation to family dysfunction or trauma* (long list of authors cited as evidence)" (pg. 54-55). Others can speak to this better- I am not confident that I know the etiology literature well enough- but even if "technically" true, such evidence does exist in significant amount of clinical reports and case studies.

The Introduction to the main document of the TFR opens with reference to "the basis of emerging scientific evidence" and "on the growing scientific evidence" (citing Gonsiorek, 1991) as rationales removal of "homosexuality" from the DSM-II, "that homosexuality per se is not a mental disorder" and that diagnosing and treating it as such perpetuated a "stigma of mental illness that the medical and mental health professions had previously placed on sexual minorities" This "*emerging* [and]…*growing scientific evidence* also led to the acceptance by "*licensed mental health providers of all professions …that homosexuality per se is a normal variant of human sexuality and that lesbian, gay, and bisexual (LGB) people deserve to be affirmed and supported in their sexual orientation* (pg. 11).

***There is no "empirical foundation," or "emerging or growing scientific evidence" for these assertions of which I am aware, short of gay activist mental health professionals and researchers asserting that they are true. The 1973 & 1974 decisions (i.e., political votes) by the APA's seem to provide self-serving proof, i.e. a circular argument: the APA's wouldn't have said so if they weren't true, and they're true because the APA's have said so.**

4. **The criteria for empirical acceptability are inconsistently applied.** None of the studies cited in support of the Task Forces "scientific facts" (pg. 2) meet their own stringent criteria (summarized on pg. 6; cf. pg. 21-22; 26-34; 42-43; 90-91). Also, as they

apply and require them, the criteria regarding sampling and control groups should and could not ever be met in a clinically responsible way.

- Ironically, the 2007 study by Jones and Yarhouse, which clearly is the most rigorous study of "SOCE" to date, is *not* mentioned in Chapter 4 which purports to be "A Systematic Review of Research on the Efficacy of SOCE: Outcomes". In footnotes, this study is included with others as being unable to "access whether actual sexual orientation change occurred…due to their methodological issues" (pg. 44). A lengthier footnote (pg. 90) criticizes in detail the "study's methodological problems", yet a fair reading of the 2007 study and the three year additional followup reported at the 2009 APA convention in Toronto clearly shows that the four of five key criteria emphasized in this Task Force Report (pg. 6) were, in fact met, and that the criteria concerning sampling and control groups could not and should not have been met. If a demonstrably empirically sound study like Jones and Yarhouse's yields results that are "unpersuasive" (pg. 90), then no further study could be persuasive. The Task Force has set the bar so artificially high that no study done in a clinically, as well as scientifically, responsible manner ever would be good enough.

- Ironically, the criteria insisted on by the Task Force could not be met by themselves. One would have to believe in the possibility and goodness of sexual orientation change as well as in the effectiveness of particular approaches to helping clients achieve such change. The way that the Task Force insists research be done would preclude either it's ever being done- or ever good enough.

5. **Two resolutions appear to accuse the likes of NARTH and religiously-mediated ministries for the very practices which the Task Force and others of their ilk themselves practice.**

- The APA "*opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion*" (pg. 122)

- The APA "supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation" (pg. 122).

6. **Spurious or novel – and non-empirically- supported distinctions obscure rather than clarify the lived realities of the lives of those with homosexual attractions and behaviors.**

- *Sexual orientation vs. sexual orientation identity*: The Task Force Report attempts to identify an objective phenomenon (orientation) vs. a subjective (identity). "Orientation" is defined as an unchangeable characteristic while "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". Pseudo-

  science, i.e., 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", pg. 2).

  Clients have and do report satisfaction with efforts to change their "sexual orientation." How you define sexual orientation affects how you measure and attempt to change this phenomenon. The fact that a person who is functionally free of homosexual obsessions and compulsions but who occasionally experiences homosexual attractions – not to mention if s/he has become functionally heterosexual in attractions and behaviors, at least to or with one's heterosexual partner- will have been helped or not depending on the "strict definition of sexual orientation.

  Finally, the 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.", not to mention any behavior habits of gratifying or expressing them. It is difficult to believe how naïve the writers of this section could be.

- *Telic congruence* ("personal or religious values", i.e., "making commitments and decisions about how to live according to specific ethics and ideals") vs. *organismic congruence* ("i.e., living with a sense of wholeness in one's experiential self" which "would give priority to the development of self-awareness and identity." While the Report acknowledges "that the organismic worldview can be congruent with and respectful of religion", the Report's discussion seems to imply that while it is "OK" to have or seek "telic congruence, organismic congruence is of greater importance. While the Report does explicitly voice for the importance of respecting religious values, it strikes me as being more slick "lip service". A more careful read and analysis of the Report's treatment of "congruence" is warranted.

7. **The discussion of the "stigma model" (pg. 15-17) fails to acknowledge that the most current research documenting the greater prevalence of medical, psychological and relational disorders among practicing homosexuals fails to support this hypothesis** (cf. Section 3, Volume 1 (2009), *Journal of Human Sexuality*).

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8. **The Report engages in misdirection and inconsistent criticism.** While emphasizing the importance for current outcome research to meet modern criteria for evidenced-based psychotherapy and declaring that attempts to document SOCE do not meet them and that its own model of affirmative therapy is in need of empirical validation, the Task Force asserts that reported benefits to clients who have engaged in SOCE are similar to those found by persons who are homosexual who sought therapy for other reasons, and therefore the (gay) affirmative approaches are valid but the SOCE are not.

9. **APA is unjustifiably mischaracterizing a process with which many clients consumers are satisfied and for which they are grateful, and thereby stigmatizing the practice of therapists who provide such care,** in claiming in its press release: *INSUFFICIENT EVIDENCE THAT SEXUAL ORIENTATION CHANGE EFFORTS WORK, SAYS APA* that "Practitioners Should Avoid Telling Clients They Can Change from Gay to Straight" (APA, 2009, http://www.apa.org/releases/therapeutic.html).

Final Note: I end here, not because I think I have commented on all that needs to be said of the Task Force Report, but because I have no more time at present to review this document. It will be important to actually review the cited references to assure that they actually say what the Report claims that the references say. Also, there are points of agreement with NARTH positions in the Report that I have not mentioned in this analysis. Keith Vennum's e-mail sent on the NARTH List-Serv from/during the APA convention.

APA Council of Representatives Resolution Rejecting Intelligent Design as Scientific and Reaffirming Support for Evolutionary Theory

The science, practice, and application of psychology depend on science education and the culture of evidence and critical thought to which it contributes. Evolutionary theory is one of the most powerful elements of contemporary science. With due diligence in repudiating misappropriations of evolution to justify social injustices, scholars informed by evolutionary theory can unify scientific knowledge and serve public interests in invaluable ways. Proponents of Intelligent Design (ID) present ID theory as a viable alternative scientific explanation for the origins and diversity of life. However, ID has not withstood the scrutiny of scientific peer review of its empirical, conceptual, or epistemological bases and thus is not properly regarded as a scientific theory.

WHEREAS Intelligent Design Theory poses a threat to the quality of science education in the United States, and recognizing the urgency pressed upon it by the endorsement of teaching ID alongside evolutionary theory by some political leaders; (Baker & Slevin, 2005; Santorum, 2005)

WHEREAS Evolutionary theory is a major unifying force in contemporary science; (Gould, 1994; National Science Teachers Association, 2003; Wilson, 1998)

WHEREAS The bases of continuity and variation that follow from evolutionary theory inform, explicitly or implicitly, the work of many psychologists with humans and other animals; (Caporael, 2001; Crawford, 1989; Gray, 1996)

WHEREAS ID proponents dismiss contemporary evolutionary theory as scientifically invalid; (Discovery Institute, n.d., Wells, 2000/2001)

WHEREAS ID proponents promulgate their theory as science in the absence of empirical evidence or, indeed, a means of testing it that passes scientific muster; (Young & Edis, 2004) and

WHEREAS The teaching of ID as science would seriously undermine both the vitality of psychological science and the science literacy so essential to an informed, responsible citizenry; (Gray, 1996; Lombrozo, Shtulman, & Weisberg, 2006; National Science Teachers Association, 2003)

THEREFORE BE IT RESOLVED that APA applauds the consistent repudiation by federal courts of Creationism, Creation Science, and now ID as a part of science education; (*Edwards v. Aguillard*, 1987; *Kitzmiller et al v. Dover Area School District*, 2005; *McLean v. Arkansas Board of Education*, 1982; *Peloza v. Capstriano Unified School District*, 1994; *Webster v. New Lennox School District*, 1990)

THEREFORE BE IT FURTHER RESOLVED that the APA reaffirms earlier relevant resolutions (APA, 1982 & 1990) and joins other leading scholarly organizations including American Association for the Advancement of Science (2002), American Astronomical Society (2005), American Society of Agronomy (2005), Federation of American Societies of Experimental Biology (2005), and National Association of Biology Teachers (2005) in opposing the teaching of Intelligent Design as a scientific theory.

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

Adopted by APA Council of Representatives, August, 16 2007

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THEREFORE BE IT FURTHER RESOLVED that psychologists are careful to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists.

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

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Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

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NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, DBA NIFLA, ET AL. *v.* BECERRA, ATTORNEY GENERAL OF CALIFORNIA, ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 16–1140. Argued March 20, 2018—Decided June 26, 2018

The California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT Act) was enacted to regulate crisis pregnancy centers—pro-life centers that offer pregnancy-related services. The FACT Act requires clinics that primarily serve pregnant women to provide certain notices. Clinics that are licensed must notify women that California provides free or low-cost services, including abortions, and give them a phone number to call. Its stated purpose is to make sure that state residents know their rights and what health care services are available to them. Unlicensed clinics must notify women that California has not licensed the clinics to provide medical services. Its stated purpose is to ensure that pregnant women know when they are receiving health care from licensed professionals. Petitioners—two crisis pregnancy centers, one licensed and one unlicensed, and an organization of crisis pregnancy centers—filed suit. They alleged that both the licensed and the unlicensed notices abridge the freedom of speech protected by the First Amendment. The District Court denied their motion for a preliminary injunction, and the Ninth Circuit affirmed. Holding that petitioners could not show a likelihood of success on the merits, the court concluded that the licensed notice survived a lower level of scrutiny applicable to regulations of "professional speech," and that the unlicensed notice satisfied any level of scrutiny.

Held:

1. The licensed notice likely violates the First Amendment. Pp. 6–17.

(a) Content-based laws "target speech based on its communicative content" and "are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Reed* v. *Town of Gilbert*, 576 U. S. ___, ___. The licensed notice is a content-based regulation. By compelling petitioners to speak a particular message, it "alters the content of [their] speech." *Riley* v. *National Federation of Blind of N. C., Inc.*, 487 U. S. 781, 795. For example, one of the state-sponsored services that the licensed notice requires petitioners to advertise is abortion—the very practice that petitioners are devoted to opposing. Pp. 6–7.

(b) Although the licensed notice is content-based, the Ninth Circuit did not apply strict scrutiny because it concluded that the notice regulates "professional speech." But this Court has never recognized "professional speech" as a separate category of speech subject to different rules. Speech is not unprotected merely because it is uttered by professionals. The Court has afforded less protection for professional speech in two circumstances—where a law requires professionals to disclose factual, noncontroversial information in their "commercial speech," see, *e.g.*, *Zauderer* v. *Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U. S. 626, 651, and where States regulate professional conduct that incidentally involves speech, see, *e.g.*, *Ohralik* v. *Ohio State Bar Assn.*, 436 U. S. 447, 456. Neither line of precedents is implicated here. Pp. 7–14.

(1) Unlike the rule in *Zauderer*, the licensed notice is not limited to "purely factual and uncontroversial information about the terms under which . . . services will be available," 471 U. S., at 651. California's notice requires covered clinics to disclose information about *state*-sponsored services—including abortion, hardly an "uncontroversial" topic. Accordingly, *Zauderer* has no application here. P. 9.

(2) Nor is the licensed notice a regulation of professional conduct that incidentally burdens speech. The Court's precedents have long drawn a line between speech and conduct. In *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833, for example, the joint opinion rejected a free-speech challenge to an informed-consent law requiring physicians to "give a woman certain information as part of obtaining her consent to an abortion," *id.*, at 884. But the licensed notice is neither an informed-consent requirement nor any other regulation of professional conduct. It applies to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed. And many other facilities providing the exact same services, such as general practice clinics, are not subject to the requirement. Pp. 10–11.

(3) Outside of these two contexts, the Court's precedents have long protected the First Amendment rights of professionals. The Court

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has applied strict scrutiny to content-based laws regulating the noncommercial speech of lawyers, see *Reed*, *supra*, at ___, professional fundraisers, see *Riley*, *supra*, at 798, and organizations providing specialized advice on international law, see *Holder* v. *Humanitarian Law Project*, 561 U. S. 1, 27–28. And it has stressed the danger of content-based regulations "in the fields of medicine and public health, where information can save lives." *Sorrell* v. *IMS Health Inc.*, 564 U. S. 552, 566. Such dangers are also present in the context of professional speech, where content-based regulation poses the same "risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information," *Turner Broadcasting Systems, Inc.* v. *FCC*, 512 U. S. 622, 641. When the government polices the content of professional speech, it can fail to " 'preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.' " *McCullen* v. *Coakley*, 573 U. S. ___, ___–___. Professional speech is also a difficult category to define with precision. See *Brown* v. *Entertainment Merchants Assn.*, 564 U. S. 786, 791. If States could choose the protection that speech receives simply by requiring a license, they would have a powerful tool to impose "invidious discrimination of disfavored subjects." *Cincinnati* v. *Discovery Network, Inc.*, 507 U. S. 410, 423, n. 19. Pp. 11–14.

(c) Although neither California nor the Ninth Circuit have advanced a persuasive reason to apply different rules to professional speech, the Court need not foreclose the possibility that some such reason exists because the licensed notice cannot survive even intermediate scrutiny. Assuming that California's interest in providing low-income women with information about state-sponsored service is substantial, the licensed notice is not sufficiently drawn to promote it. The notice is "wildly underinclusive," *Entertainment Merchants Assn.*, *supra*, at 802, because it applies only to clinics that have a "primary purpose" of "providing family planning or pregnancy-related services" while excluding several other types of clinics that also serve low-income women and could educate them about the State's services. California could also inform the women about its services "without burdening a speaker with unwanted speech," *Riley*, *supra*, at 800, most obviously through a public-information campaign. Petitioners are thus likely to succeed on the merits of their challenge. Pp. 14–17.

2. The unlicensed notice unduly burdens protected speech. It is unnecessary to decide whether *Zauderer*'s standard applies here, for even under *Zauderer*, a disclosure requirement cannot be "unjustified or unduly burdensome." 471 U. S., at 651. Disclosures must remedy a harm that is "potentially real not purely hypothetical," *Ibanez* v. *Florida Dept. of Business and Professional Regulation, Bd. of Accountancy*, 512 U. S. 136, 146, and can extend "no broader than reasonably necessary," *In re R. M. J.*, 455 U. S. 191, 203. California has not demonstrated any justification for the unlicensed notice that is more than "purely hypothetical." The only justification put forward by the state legislature was ensuring that pregnant women know when they are receiving medical care from licensed professionals, but California denied that the justification for the law was that women did not know what kind of facility they are entering when they go to a crisis pregnancy center. Even if the State had presented a nonhypothetical justification, the FACT Act unduly burdens protected speech. It imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from the State's informational interest. It requires covered facilities to post California's precise notice, no matter what the facilities say on site or in their advertisements. And it covers a curiously narrow subset of speakers: those that primarily provide pregnancy-related services, but not those that provide, *e.g.*, nonprescription birth control. Such speaker-based laws run the risk that "the State has left unburdened those speakers whose messages are in accord with its own views." *Sorrell*, *supra*, at 580. For these reasons, the unlicensed notice does not satisfy *Zauderer*, assuming that standard applies. Pp. 17–20.

839 F. 3d 823, reversed and remanded.

THOMAS, J., delivered the opinion of the Court, in which ROBERTS, C. J., and KENNEDY, ALITO, and GORSUCH, JJ., joined. KENNEDY, J., filed a concurring opinion, in which ROBERTS, C. J., and ALITO and GORSUCH, JJ., joined. BREYER, J., filed dissenting opinion, in which GINSBURG, SOTOMAYOR, and KAGAN, JJ., joined.

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NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 16–1140

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, DBA NIFLA, ET AL., PETITIONERS *v.* XAVIER BECERRA, ATTORNEY GENERAL OF CALIFORNIA, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

[June 26, 2018]

JUSTICE THOMAS delivered the opinion of the Court.

The California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT Act) requires clinics that primarily serve pregnant women to provide certain notices. Cal. Health & Safety Code Ann. §123470 *et seq.* (West 2018). Licensed clinics must notify women that California provides free or low-cost services, including abortions, and give them a phone number to call. Unlicensed clinics must notify women that California has not licensed the clinics to provide medical services. The question in this case is whether these notice requirements violate the First Amendment.

I

A

The California State Legislature enacted the FACT Act to regulate crisis pregnancy centers. Crisis pregnancy centers—according to a report commissioned by the California State Assembly, App. 86—are "pro-life (largely Christian belief-based) organizations that offer a limited

range of free pregnancy options, counseling, and other services to individuals that visit a center." Watters et al., Pregnancy Resource Centers: Ensuring Access and Accuracy of Information 4 (2011). "[U]nfortunately," the author of the FACT Act stated, "there are nearly 200 licensed and unlicensed" crisis pregnancy centers in California. App. 84. These centers "aim to discourage and prevent women from seeking abortions." *Id.,* at 85. The author of the FACT Act observed that crisis pregnancy centers "are commonly affiliated with, or run by organizations whose stated goal" is to oppose abortion—including "the National Institute of Family and Life Advocates," one of the petitioners here. *Ibid.* To address this perceived problem, the FACT Act imposes two notice requirements on facilities that provide pregnancy-related services—one for licensed facilities and one for unlicensed facilities.

1

The first notice requirement applies to "licensed covered facilit[ies]." Cal. Health & Safety Code Ann. §123471(a). To fall under the definition of "licensed covered facility," a clinic must be a licensed primary care or specialty clinic or qualify as an intermittent clinic under California law. *Ibid.* (citing §§1204, 1206(h)). A licensed covered facility also must have the "primary purpose" of "providing family planning or pregnancy-related services." §123471(a). And it must satisfy at least two of the following six requirements:

> "(1) The facility offers obstetric ultrasounds, obstetric sonograms, or prenatal care to pregnant women.
>
> "(2) The facility provides, or offers counseling about, contraception or contraceptive methods.
>
> "(3) The facility offers pregnancy testing or pregnancy diagnosis.
>
> "(4) The facility advertises or solicits patrons with offers to provide prenatal sonography, pregnancy tests, or pregnancy options counseling.
>
> "(5) The facility offers abortion services.
>
> "(6) The facility has staff or volunteers who collect health information from clients." *Ibid.*

The FACT Act exempts several categories of clinics that would otherwise qualify as licensed covered facilities. Clinics operated by the United States or a federal agency are excluded, as are clinics that are "enrolled as a Medi-Cal provider" and participate in "the Family Planning, Access, Care, and Treatment Program" (Family PACT program). §123471(c). To participate in the Family PACT program, a clinic must provide "the full scope of family planning . . . services specified for the program," Cal. Welf. & Inst. Code Ann. §24005(c) (West 2018), including sterilization and emergency contraceptive pills, §§24007(a)(1), (2).

If a clinic is a licensed covered facility, the FACT Act requires it to disseminate a government-drafted notice on site. Cal. Health & Safety Code Ann. §123472(a)(1). The notice states that "California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number]." *Ibid.* This notice must be posted in the waiting room, printed and distributed to all clients, or provided digitally at check-in. §123472(a)(2). The notice must be in English and any additional languages identified by state law. §123472(a). In some counties, that means the notice must be spelled out in 13 different languages. See State of Cal., Dept. of Health Care Services, Frequency of Threshold Language Speakers in the Medi-Cal Population by County for Jan. 2015, pp. 4–5 (Sept. 2016) (identifying the required languages for Los Angeles County as English, Spanish, Armenian, Mandarin, Cantonese, Korean, Vietnamese, Farsi, Tagalog, Russian, Cambodian, Other Chinese, and Arabic).

The stated purpose of the FACT Act, including its licensed notice requirement, is to "ensure that California residents make their personal reproductive health care decisions knowing their rights and the health care services available to them." 2015 Cal. Legis. Serv. Ch. 700, §2 (A. B. 775) (West) (Cal. Legis. Serv.). The Legislature posited that "thousands of women remain unaware of the public programs available to provide them with contraception, health education and counseling, family planning, prenatal care, abortion, or delivery." §1(b). Citing the "time sensitive" nature of pregnancy-related decisions, §1(c), the Legislature concluded that requiring licensed facilities to inform patients themselves would be "[t]he most effective" way to convey this information, §1(d).

2

The second notice requirement in the FACT Act applies to "unlicensed covered facilit[ies]." §123471(b). To fall under the definition of "unlicensed covered facility," a facility must not be licensed by the State, not have a licensed medical provider on staff or under contract, and have the "primary purpose" of "providing pregnancy-related services." *Ibid.* An unlicensed covered facility also must satisfy at least two of the following four requirements:

> "(1) The facility offers obstetric ultrasounds, obstetric sonograms, or prenatal care to pregnant women.
>
> "(2) The facility offers pregnancy testing or pregnancy diagnosis.
>
> "(3) The facility advertises or solicits patrons with of-

fers to provide prenatal sonography, pregnancy tests, or pregnancy options counseling.

"(4) The facility has staff or volunteers who collect health information from clients." *Ibid.*

Clinics operated by the United States and licensed primary care clinics enrolled in Medi-Cal and Family PACT are excluded. §123471(c).

Unlicensed covered facilities must provide a government-drafted notice stating that "[t]his facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services." Cal. Health & Safety Code Ann. §123472(b)(1). This notice must be provided on site and in all advertising materials. §§123472(b)(2), (3). Onsite, the notice must be posted "conspicuously" at the entrance of the facility and in at least one waiting area. §123472(b)(2). It must be "at least 8.5 inches by 11 inches and written in no less than 48-point type." *Ibid.* In advertisements, the notice must be in the same size or larger font than the surrounding text, or otherwise set off in a way that draws attention to it. §123472(b)(3). Like the licensed notice, the unlicensed notice must be in English and any additional languages specified by state law. §123471(b). Its stated purpose is to ensure "that pregnant women in California know when they are getting medical care from licensed professionals." Cal. Legis. Serv., §1(e).

B

After the Governor of California signed the FACT Act, petitioners—a licensed pregnancy center, an unlicensed pregnancy center, and an organization composed of crisis pregnancy centers—filed this suit. Petitioners alleged that the licensed and unlicensed notices abridge the freedom of speech protected by the First Amendment. The District Court denied their motion for a preliminary

injunction.

The Court of Appeals for the Ninth Circuit affirmed. *National Institute of Family and Life Advocates* v. *Harris*, 839 F. 3d 823, 845 (2016). After concluding that petitioners' challenge to the FACT Act was ripe,[1] *id.*, at 833, the Ninth Circuit held that petitioners could not show a likelihood of success on the merits. It concluded that the licensed notice survives the "lower level of scrutiny" that applies to regulations of "professional speech." *Id.*, at 833–842. And it concluded that the unlicensed notice satisfies any level of scrutiny. See *id.*, at 843–844.

We granted certiorari to review the Ninth Circuit's decision. 583 U. S. ___ (2017). We reverse with respect to both notice requirements.

II

We first address the licensed notice.[2]

A

The First Amendment, applicable to the States through the Fourteenth Amendment, prohibits laws that abridge the freedom of speech. When enforcing this prohibition, our precedents distinguish between content-based and content-neutral regulations of speech. Content-based regulations "target speech based on its communicative content." *Reed* v. *Town of Gilbert*, 576 U. S. ___, ___ (2015) (slip op., at 6). As a general matter, such laws "are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Ibid.* This stringent standard reflects the fundamental principle that govern-

[1] We agree with the Ninth Circuit's ripeness determination.

[2] Petitioners raise serious concerns that both the licensed and unlicensed notices discriminate based on viewpoint. Because the notices are unconstitutional either way, as explained below, we need not reach that issue.

ments have "'no power to restrict expression because of its message, its ideas, its subject matter, or its content.'" *Ibid.* (quoting *Police Dept. of Chicago* v. *Mosley*, 408 U. S. 92, 95 (1972)).

The licensed notice is a content-based regulation of speech. By compelling individuals to speak a particular message, such notices "alte[r] the content of [their] speech." *Riley* v. *National Federation of Blind of N. C., Inc.*, 487 U. S. 781, 795 (1988); accord, *Turner Broadcasting System, Inc.* v. *FCC*, 512 U. S. 622, 642 (1994); *Miami Herald Publishing Co.* v. *Tornillo*, 418 U. S. 241, 256 (1974). Here, for example, licensed clinics must provide a government-drafted script about the availability of state-sponsored services, as well as contact information for how to obtain them. One of those services is abortion—the very practice that petitioners are devoted to opposing. By requiring petitioners to inform women how they can obtain state-subsidized abortions—at the same time petitioners try to dissuade women from choosing that option—the licensed notice plainly "alters the content" of petitioners' speech. *Riley*, *supra*, at 795.

B

Although the licensed notice is content based, the Ninth Circuit did not apply strict scrutiny because it concluded that the notice regulates "professional speech." 839 F. 3d, at 839. Some Courts of Appeals have recognized "professional speech" as a separate category of speech that is subject to different rules. See, *e.g.*, *King* v. *Governors of New Jersey*, 767 F. 3d 216, 232 (CA3 2014); *Pickup* v. *Brown*, 740 F. 3d 1208, 1227–1229 (CA9 2014); *Moore-King* v. *County of Chesterfield*, 708 F. 3d 560, 568–570 (CA4 2014). These courts define "professionals" as individuals who provide personalized services to clients and who are subject to "a generally applicable licensing and regulatory regime." *Id.*, at 569; see also, *King*, *supra*, at

232; *Pickup*, *supra*, at 1230. "Professional speech" is then defined as any speech by these individuals that is based on "[their] expert knowledge and judgment," *King*, *supra*, at 232, or that is "within the confines of [the] professional relationship," *Pickup*, *supra*, at 1228. So defined, these courts except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny. See *King*, *supra*, at 232; *Pickup*, *supra*, at 1053–1056; *Moore-King*, *supra*, at 569.

But this Court has not recognized "professional speech" as a separate category of speech. Speech is not unprotected merely because it is uttered by "professionals." This Court has "been reluctant to mark off new categories of speech for diminished constitutional protection." *Denver Area Ed. Telecommunications Consortium, Inc.* v. *FCC*, 518 U. S. 727, 804 (1996) (KENNEDY, J., concurring in part, concurring in judgment in part, and dissenting in part). And it has been especially reluctant to "exemp[t] a category of speech from the normal prohibition on content-based restrictions." *United States* v. *Alvarez*, 567 U. S. 709, 722 (2012) (plurality opinion). This Court's precedents do not permit governments to impose content-based restrictions on speech without "'persuasive evidence . . . of a long (if heretofore unrecognized) tradition'" to that effect. *Ibid.* (quoting *Brown* v. *Entertainment Merchants Assn.*, 564 U. S. 786, 792 (2011)).

This Court's precedents do not recognize such a tradition for a category called "professional speech." This Court has afforded less protection for professional speech in two circumstances—neither of which turned on the fact that professionals were speaking. First, our precedents have applied more deferential review to some laws that require professionals to disclose factual, noncontroversial information in their "commercial speech." See, *e.g.*, *Zauderer* v. *Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U. S. 626, 651 (1985); *Milavetz, Gallop & Milavetz,*

P. A. v. *United States*, 559 U. S. 229, 250 (2010); *Ohralik* v. *Ohio State Bar Assn.*, 436 U. S. 447, 455–456 (1978). Second, under our precedents, States may regulate professional conduct, even though that conduct incidentally involves speech. See, *e.g., id.*, at 456; *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833, 884 (1992) (opinion of O'Connor, KENNEDY, and Souter, JJ.). But neither line of precedents is implicated here.

1

This Court's precedents have applied a lower level of scrutiny to laws that compel disclosures in certain contexts. In *Zauderer*, for example, this Court upheld a rule requiring lawyers who advertised their services on a contingency-fee basis to disclose that clients might be required to pay some fees and costs. 471 U. S., at 650–653. Noting that the disclosure requirement governed only "commercial advertising" and required the disclosure of "purely factual and uncontroversial information about the terms under which . . . services will be available," the Court explained that such requirements should be upheld unless they are "unjustified or unduly burdensome." *Id.,* at 651.

The *Zauderer* standard does not apply here. Most obviously, the licensed notice is not limited to "purely factual and uncontroversial information about the terms under which . . . services will be available." 471 U. S., at 651; see also *Hurley* v. *Irish-American Gay, Lesbian and Bisexual Group of Boston, Inc.*, 515 U. S. 557, 573 (1995) (explaining that *Zauderer* does not apply outside of these circumstances). The notice in no way relates to the services that licensed clinics provide. Instead, it requires these clinics to disclose information about *state*-sponsored services—including abortion, anything but an "uncontroversial" topic. Accordingly, *Zauderer* has no application here.

2

In addition to disclosure requirements under *Zauderer*, this Court has upheld regulations of professional conduct that incidentally burden speech. "[T]he First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech," *Sorrell* v. *IMS Health Inc.*, 564 U. S. 552, 567 (2011), and professionals are no exception to this rule, see *Ohralik*, *supra*, at 456. Longstanding torts for professional malpractice, for example, "fall within the traditional purview of state regulation of professional conduct." *NAACP* v. *Button*, 371 U. S. 415, 438 (1963); but cf. *id.,* at 439 ("[A] State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights"). While drawing the line between speech and conduct can be difficult, this Court's precedents have long drawn it, see, *e.g., Sorrell*, *supra*, at 567; *Giboney* v. *Empire Storage & Ice Co.*, 336 U. S. 490, 502 (1949), and the line is "'long familiar to the bar,'" *United States* v. *Stevens*, 559 U. S. 460, 468 (2010) (quoting *Simon & Schuster, Inc.* v. *Members of N. Y State Crime Victims Bd.*, 502 U. S. 105, 127 (1991) (KENNEDY, J., concurring in judgment)).

In *Planned Parenthood of Southeastern Pa.* v. *Casey*, for example, this Court upheld a law requiring physicians to obtain informed consent before they could perform an abortion. 505 U. S., at 884 (joint opinion of O'Connor, KENNEDY, and Souter, JJ.). Pennsylvania law required physicians to inform their patients of "the nature of the procedure, the health risks of the abortion and childbirth, and the 'probable gestational age of the unborn child.'" *Id.,* at 881. The law also required physicians to inform patients of the availability of printed materials from the State, which provided information about the child and various forms of assistance. *Ibid.*

The joint opinion in *Casey* rejected a free-speech challenge to this informed-consent requirement. *Id.*, at 884. It

described the Pennsylvania law as "a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion," which "for constitutional purposes, [was] no different from a requirement that a doctor give certain specific information about any medical procedure." *Ibid.* The joint opinion explained that the law regulated speech only "as part of the *practice* of medicine, subject to reasonable licensing and regulation by the State." *Ibid.* (emphasis added). Indeed, the requirement that a doctor obtain informed consent to perform an operation is "firmly entrenched in American tort law." *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U. S. 261, 269 (1990); see, *e.g., Schloendorff* v. *Society of N. Y. Hospital*, 211 N. Y. 125, 129–130, 105 N. E. 92, 93 (1914) (Cardozo, J.) (explaining that "a surgeon who performs an operation without his patient's consent commits an assault").

The licensed notice at issue here is not an informed-consent requirement or any other regulation of professional conduct. The notice does not facilitate informed consent to a medical procedure. In fact, it is not tied to a procedure at all. It applies to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed. If a covered facility does provide medical procedures, the notice provides no information about the risks or benefits of those procedures. Tellingly, many facilities that provide the exact same services as covered facilities—such as general practice clinics, see §123471(a)—are not required to provide the licensed notice. The licensed notice regulates speech as speech.

3

Outside of the two contexts discussed above—disclosures under *Zauderer* and professional conduct—this Court's precedents have long protected the First Amendment rights of professionals. For example, this Court has

applied strict scrutiny to content-based laws that regulate the noncommercial speech of lawyers, see *Reed*, 576 U. S., at ___ (slip op., at 10) (discussing *Button*, *supra*, at 438); *In re Primus*, 436 U. S. 412, 432 (1978); professional fundraisers, see *Riley*, 487 U. S., at 798; and organizations that provided specialized advice about international law, see *Holder* v. *Humanitarian Law Project*, 561 U. S. 1, 27–28 (2010). And the Court emphasized that the lawyer's statements in *Zauderer* would have been "fully protected" if they were made in a context other than advertising. 471 U. S., at 637, n. 7. Moreover, this Court has stressed the danger of content-based regulations "in the fields of medicine and public health, where information can save lives." *Sorrell*, *supra*, at 566.

The dangers associated with content-based regulations of speech are also present in the context of professional speech. As with other kinds of speech, regulating the content of professionals' speech "pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information." *Turner Broadcasting,* 512 U. S., at 641. Take medicine, for example. "Doctors help patients make deeply personal decisions, and their candor is crucial." *Wollschlaeger* v. *Governor of Florida*, 848 F. 3d 1293, 1328 (CA11 2017) (en banc) (W. Pryor, J. concurring). Throughout history, governments have "manipulat[ed] the content of doctor-patient discourse" to increase state power and suppress minorities:

> "For example, during the Cultural Revolution, Chinese physicians were dispatched to the countryside to convince peasants to use contraception. In the 1930s, the Soviet government expedited completion of a construction project on the Siberian railroad by ordering doctors to both reject requests for medical leave from work and conceal this government order from their

patients. In Nazi Germany, the Third Reich systematically violated the separation between state ideology and medical discourse. German physicians were taught that they owed a higher duty to the 'health of the Volk' than to the health of individual patients. Recently, Nicolae Ceausescu's strategy to increase the Romanian birth rate included prohibitions against giving advice to patients about the use of birth control devices and disseminating information about the use of condoms as a means of preventing the transmission of AIDS." Berg, Toward a First Amendment Theory of Doctor-Patient Discourse and the Right To Receive Unbiased Medical Advice, 74 B. U. L. Rev. 201, 201–202 (1994) (footnotes omitted).

Further, when the government polices the content of professional speech, it can fail to "'preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.'" *McCullen* v. *Coakley*, 573 U. S. ___, ___–___ (2014) (slip op., at 8–9). Professionals might have a host of good-faith disagreements, both with each other and with the government, on many topics in their respective fields. Doctors and nurses might disagree about the ethics of assisted suicide or the benefits of medical marijuana; lawyers and marriage counselors might disagree about the prudence of prenuptial agreements or the wisdom of divorce; bankers and accountants might disagree about the amount of money that should be devoted to savings or the benefits of tax reform. "[T]he best test of truth is the power of the thought to get itself accepted in the competition of the market," *Abrams* v. *United States*, 250 U. S. 616, 630 (1919) (Holmes, J., dissenting), and the people lose when the government is the one deciding which ideas should prevail.

"Professional speech" is also a difficult category to define with precision. See *Entertainment Merchants Assn.*, 564

U. S., at 791. As defined by the courts of appeals, the professional-speech doctrine would cover a wide array of individuals—doctors, lawyers, nurses, physical therapists, truck drivers, bartenders, barbers, and many others. See Smolla, Professional Speech and the First Amendment, 119 W. Va. L. Rev. 67, 68 (2016). One court of appeals has even applied it to fortune tellers. See *Moore-King*, 708 F. 3d, at 569. All that is required to make something a "profession," according to these courts, is that it involves personalized services and requires a professional license from the State. But that gives the States unfettered power to reduce a group's First Amendment rights by simply imposing a licensing requirement. States cannot choose the protection that speech receives under the First Amendment, as that would give them a powerful tool to impose "invidious discrimination of disfavored subjects." *Cincinnati* v. *Discovery Network, Inc.*, 507 U. S. 410, 423–424, n. 19 (1993); see also *Riley*, 487 U. S., at 796 ("[S]tate labels cannot be dispositive of [the] degree of First Amendment protection" (citing *Bigelow* v. *Virginia*, 421 U. S. 809, 826 (1975)).

C

In sum, neither California nor the Ninth Circuit has identified a persuasive reason for treating professional speech as a unique category that is exempt from ordinary First Amendment principles. We do not foreclose the possibility that some such reason exists. We need not do so because the licensed notice cannot survive even intermediate scrutiny. California asserts a single interest to justify the licensed notice: providing low-income women with information about state-sponsored services. Assuming that this is a substantial state interest, the licensed notice is not sufficiently drawn to achieve it.

If California's goal is to educate low-income women about the services it provides, then the licensed notice is

"wildly underinclusive." *Entertainment Merchants Assn.*, *supra*, at 802. The notice applies only to clinics that have a "primary purpose" of "providing family planning or pregnancy-related services" and that provide two of six categories of specific services. §123471(a). Other clinics that have another primary purpose, or that provide only one category of those services, also serve low-income women and could educate them about the State's services. According to the legislative record, California has "nearly 1,000 community clinics"—including "federally designated community health centers, migrant health centers, rural health centers, and frontier health centers"—that "serv[e] more than 5.6 million patients . . . annually through over 17 million patient encounters." App. 58. But most of those clinics are excluded from the licensed notice requirement without explanation. Such "[u]nderinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint." *Entertainment Merchants Assn.*, 564 U. S., at 802.

The FACT Act also excludes, without explanation, federal clinics and Family PACT providers from the licensed-notice requirement. California notes that those clinics can enroll women in California's programs themselves, but California's stated interest is informing women that these services exist in the first place. California has identified no evidence that the exempted clinics are more likely to provide this information than the covered clinics. In fact, the exempted clinics have long been able to enroll women in California's programs, but the FACT Act was premised on the notion that "thousands of women remain unaware of [them]." Cal. Legis. Serv., §1(b). If the goal is to maximize women's awareness of these programs, then it would seem that California would ensure that the places that can immediately enroll women also provide this information. The FACT Act's exemption for these clinics, which serve

many women who are pregnant or could become pregnant in the future, demonstrates the disconnect between its stated purpose and its actual scope. Yet "[p]recision . . . must be the touchstone" when it comes to regulations of speech, which "so closely touc[h] our most precious freedoms." *Button*, 371 U. S., at 438.

Further, California could inform low-income women about its services "without burdening a speaker with unwanted speech." *Riley*, 487 U. S., at 800. Most obviously, it could inform the women itself with a public-information campaign. See *ibid.* (concluding that a compelled disclosure was unconstitutional because the government could "itself publish . . . the disclosure"). California could even post the information on public property near crisis pregnancy centers. California argues that it has already tried an advertising campaign, and that many women who are eligible for publicly-funded healthcare have not enrolled. But California has identified no evidence to that effect. And regardless, a "tepid response" does not prove that an advertising campaign is not a sufficient alternative. *United States* v. *Playboy Entertainment Group, Inc.*, 529 U. S. 803, 816 (2000). Here, for example, individuals might not have enrolled in California's services because they do not want them, or because California spent insufficient resources on the advertising campaign. Either way, California cannot co-opt the licensed facilities to deliver its message for it. "[T]he First Amendment does not permit the State to sacrifice speech for efficiency." *Riley*, *supra*, at 795; accord, *Arizona Free Enterprise Club's Freedom Club PAC* v. *Bennett*, 564 U. S. 721, 747 (2011).

In short, petitioners are likely to succeed on the merits of their challenge to the licensed notice. Contrary to the suggestion in the dissent, *post*, at 3–4 (opinion of BREYER, J.), we do not question the legality of health and safety warnings long considered permissible, or purely factual

and uncontroversial disclosures about commercial products.

III

We next address the unlicensed notice. The parties dispute whether the unlicensed notice is subject to deferential review under *Zauderer*.[3] We need not decide whether the *Zauderer* standard applies to the unlicensed notice. Even under *Zauderer*, a disclosure requirement cannot be "unjustified or unduly burdensome." 471 U. S., at 651. Our precedents require disclosures to remedy a harm that is "potentially real not purely hypothetical," *Ibanez* v. *Florida Dept. of Business and Professional Regulation, Bd. of Accountancy*, 512 U. S. 136, 146 (1994), and to extend "no broader than reasonably necessary," *In re R. M. J.*, 455 U. S. 191, 203 (1982); accord, *Virginia Bd. of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.*, 425 U. S. 748, 772, n. 24 (1976); *Bates* v. *State Bar of Ariz.*, 433 U. S. 350, 384 (1977); cf. *Zauderer*, 471 U. S., at 649 (rejecting "broad prophylactic rules" in this area). Otherwise, they risk "chilling" protected speech." *Id.,* at 651. Importantly, California has the burden to prove that the unlicensed notice is neither unjustified nor unduly burdensome. See *Ibanez*, 512 U. S., at 146. It has not met its burden.

We need not decide what type of state interest is sufficient to sustain a disclosure requirement like the unlicensed notice. California has not demonstrated any justification for the unlicensed notice that is more than "purely hypothetical." *Ibid.* The only justification that the California Legislature put forward was ensuring that "pregnant women in California know when they are getting

[3]Other than a conclusory assertion that the unlicensed notice satisfies any standard of review, see Brief for Respondents 19, California does not explain how the unlicensed notice could satisfy any standard other than *Zauderer*.

medical care from licensed professionals." 2015 Cal. Legis. Serv., §1(e). At oral argument, however, California denied that the justification for the FACT Act was that women "go into [crisis pregnancy centers] and they don't realize what they are." See Tr. of Oral Arg. at 44–45. Indeed, California points to nothing suggesting that pregnant women do not already know that the covered facilities are staffed by unlicensed medical professionals. The services that trigger the unlicensed notice—such as having "volunteers who collect health information from clients," "advertis[ing] . . . pregnancy options counseling," and offering over-the-counter "pregnancy testing," §123471(b)—do not require a medical license. And California already makes it a crime for individuals without a medical license to practice medicine. See Cal. Bus. & Prof. Code Ann. §2052. At this preliminary stage of the litigation, we agree that petitioners are likely to prevail on the question whether California has proved a justification for the unlicensed notice.[4]

Even if California had presented a nonhypothetical justification for the unlicensed notice, the FACT Act unduly burdens protected speech. The unlicensed notice imposes a government-scripted, speaker-based disclosure requirement that is wholly disconnected from California's informational interest. It requires covered facilities to post California's precise notice, no matter what the facilities say on site or in their advertisements. And it covers a curiously narrow subset of speakers. While the licensed notice applies to facilities that provide "family planning" services and "contraception or contraceptive methods," §123471(a), the California Legislature dropped these triggering conditions for the unlicensed notice. The unli-

[4]Nothing in our opinion should be read to foreclose the possibility that California will gather enough evidence in later stages of this litigation.

censed notice applies only to facilities that primarily provide "pregnancy-related" services. §123471(b). Thus, a facility that advertises and provides pregnancy tests is covered by the unlicensed notice, but a facility across the street that advertises and provides nonprescription contraceptives is excluded—even though the latter is no less likely to make women think it is licensed. This Court's precedents are deeply skeptical of laws that "distinguis[h] among different speakers, allowing speech by some but not others." *Citizens United* v. *Federal Election Comm'n*, 558 U. S. 310, 340 (2010). Speaker-based laws run the risk that "the State has left unburdened those speakers whose messages are in accord with its own views." *Sorrell*, 564 U. S., at 580.

The application of the unlicensed notice to advertisements demonstrates just how burdensome it is. The notice applies to all "print and digital advertising materials" by an unlicensed covered facility. §123472(b). These materials must include a government-drafted statement that "[t]his facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services." §123472(b)(1). An unlicensed facility must call attention to the notice, instead of its own message, by some method such as larger text or contrasting type or color. See §§123472(b)(2)–(3). This scripted language must be posted in English and as many other languages as California chooses to require. As California conceded at oral argument, a billboard for an unlicensed facility that says "Choose Life" would have to surround that two-word statement with a 29-word statement from the government, in as many as 13 different languages. In this way, the unlicensed notice drowns out the facility's own message. More likely, the "detail required" by the unlicensed notice "effectively rules out" the possibility of having such a billboard in the first place. *Ibanez*, *supra*, at 146.

For all these reasons, the unlicensed notice does not satisfy *Zauderer*, assuming that standard applies. California has offered no justification that the notice plausibly furthers. It targets speakers, not speech, and imposes an unduly burdensome disclosure requirement that will chill their protected speech. Taking all these circumstances together, we conclude that the unlicensed notice is unjustified and unduly burdensome under *Zauderer*. We express no view on the legality of a similar disclosure requirement that is better supported or less burdensome.

IV

We hold that petitioners are likely to succeed on the merits of their claim that the FACT Act violates the First Amendment. We reverse the judgment of the Court of Appeals and remand the case for further proceedings consistent with this opinion.

It is so ordered.

SUPREME COURT OF THE UNITED STATES

No. 16–1140

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, DBA NIFLA, ET AL., PETITIONERS *v.* XAVIER BECERRA, ATTORNEY GENERAL OF CALIFORNIA, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

[June 26, 2018]

JUSTICE KENNEDY, with whom THE CHIEF JUSTICE, JUSTICE ALITO, and JUSTICE GORSUCH join, concurring.

I join the Court's opinion in all respects.

This separate writing seeks to underscore that the apparent viewpoint discrimination here is a matter of serious constitutional concern. See *ante*, at 6, n. 2. The Court, in my view, is correct not to reach this question. It was not sufficiently developed, and the rationale for the Court's decision today suffices to resolve the case. And had the Court's analysis been confined to viewpoint discrimination, some legislators might have inferred that if the law were reenacted with a broader base and broader coverage it then would be upheld.

It does appear that viewpoint discrimination is inherent in the design and structure of this Act. This law is a paradigmatic example of the serious threat presented when government seeks to impose its own message in the place of individual speech, thought, and expression. For here the State requires primarily pro-life pregnancy centers to promote the State's own preferred message advertising abortions. This compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts, or all of these.

And the history of the Act's passage and its underinclusive application suggest a real possibility that these individuals were targeted because of their beliefs.

The California Legislature included in its official history the congratulatory statement that the Act was part of California's legacy of "forward thinking." App. 38–39. But it is not forward thinking to force individuals to "be an instrument for fostering public adherence to an ideological point of view [they] fin[d] unacceptable." *Wooley* v. *Maynard*, 430 U. S. 705, 715 (1977). It is forward thinking to begin by reading the First Amendment as ratified in 1791; to understand the history of authoritarian government as the Founders then knew it; to confirm that history since then shows how relentless authoritarian regimes are in their attempts to stifle free speech; and to carry those lessons onward as we seek to preserve and teach the necessity of freedom of speech for the generations to come. Governments must not be allowed to force persons to express a message contrary to their deepest convictions. Freedom of speech secures freedom of thought and belief. This law imperils those liberties.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

[June 26, 2018]

JUSTICE BREYER, with whom JUSTICE GINSBURG, JUSTICE SOTOMAYOR, and JUSTICE KAGAN join, dissenting.

The petitioners ask us to consider whether two sections of a California statute violate the First Amendment. The first section requires licensed medical facilities (that provide women with assistance involving pregnancy or family planning) to tell those women where they might obtain help, including financial help, with comprehensive family planning services, prenatal care, and abortion. The second requires *un*licensed facilities offering somewhat similar services to make clear that they are unlicensed. In my view both statutory sections are likely constitutional, and I dissent from the Court's contrary conclusions.

I

The first statutory section applies to licensed medical facilities dealing with pregnancy and which also provide specific services such as prenatal care, contraception counseling, pregnancy diagnosis, or abortion-related services. Cal. Health & Safety Code Ann. §§123471(a), 1204, 1206(h) (West 2018) (covering "primary care clinics" that serve low-income women); Cal. Code Regs., tit. 22, §75026 (2018) ("primary care clinics" are medical facilities that

provide "services for the care and treatment of patients for whom the clinic accepts responsibility" with the "direction or supervision" of each "service" undertaken "by a person licensed, certified or registered to provide such service").

The statute requires these facilities to post a notice in their waiting rooms telling their patients:

> "California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number]." §123472(a)(1).

The petitioners here, a group of covered medical facilities that object to abortion for religious reasons, brought this case seeking an injunction against enforcement of the California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act on the ground that it violates the First Amendment on its face. The District Court denied a preliminary injunction, and the Court of Appeals affirmed. The majority now reverses the Court of Appeals on the ground that the petitioners have shown a likelihood of success on the merits, *i.e.*, that the statute likely violates the petitioners' free speech rights and is unconstitutional on its face.

A

Before turning to the specific law before us, I focus upon the general interpretation of the First Amendment that the majority says it applies. It applies heightened scrutiny to the Act because the Act, in its view, is "content based." *Ante,* at 6–7. "By compelling individuals to speak a particular message," it adds, "such notices 'alte[r] the content of [their] speech.'" *Ante,* at 7 (quoting *Riley* v. *National Federation of Blind of N. C., Inc.*, 487 U. S. 781,

795 (1988)) (alteration in original). "As a general matter," the majority concludes, such laws are "presumptively unconstitutional" and are subject to "stringent" review. *Ante,* at 6–7.

The majority recognizes exceptions to this general rule: It excepts laws that "require professionals to disclose factual, noncontroversial information in their 'commercial speech,' " *provided that* the disclosure "relates to the services that [the regulated entities] provide." *Ante,* at 8–9. It also excepts laws that "regulate professional conduct" *and* only "incidentally burden speech." *Ante,* at 9–10.

This constitutional approach threatens to create serious problems. Because much, perhaps most, human behavior takes place through speech and because much, perhaps most, law regulates that speech in terms of its content, the majority's approach at the least threatens considerable litigation over the constitutional validity of much, perhaps most, government regulation. Virtually every disclosure law could be considered "content based," for virtually every disclosure law requires individuals "to speak a particular message." See *Reed* v. *Town of Gilbert*, 576 U. S. ___, ___ (2015) (BREYER, J., concurring in judgment) (slip op., at 3) (listing regulations that inevitably involve content discrimination, ranging from securities disclosures to signs at petting zoos). Thus, the majority's view, if taken literally, could radically change prior law, perhaps placing much securities law or consumer protection law at constitutional risk, depending on how broadly its exceptions are interpreted.

Many ordinary disclosure laws would fall outside the majority's exceptions for disclosures related to the professional's own services or conduct. These include numerous commonly found disclosure requirements relating to the medical profession. See, *e.g.*, Cal. Veh. Code Ann. §27363.5 (West 2014) (requiring hospitals to tell parents about child seat belts); Cal. Health & Safety Code Ann.

§123222.2 (requiring hospitals to ask incoming patients if they would like the facility to give their family information about patients' rights and responsibilities); N. C. Gen. Stat. Ann. §131E–79.2 (2017) (requiring hospitals to tell parents of newborns about pertussis disease and the available vaccine). These also include numerous disclosure requirements found in other areas. See, *e.g.,* N. Y. C. Rules & Regs., tit. 1, §27–01 (2018) (requiring signs by elevators showing stair locations); San Francisco Dept. of Health, Director's Rules & Regs., Garbage and Refuse (July 8, 2010) (requiring property owners to inform tenants about garbage disposal procedures).

The majority, at the end of Part II of its opinion, perhaps recognizing this problem, adds a general disclaimer. It says that it does not "question the legality of health and safety warnings long considered permissible, or purely factual and uncontroversial disclosures about commercial products." *Ante,* at 16–17. But this generally phrased disclaimer would seem more likely to invite litigation than to provide needed limitation and clarification. The majority, for example, does not explain why the Act here, which is justified in part by health and safety considerations, does not fall within its "health" category. *Ante,* at 14; see also *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833, 882–884 (1992) (joint opinion of O'Connor, KENNEDY, and Souter, JJ.) (reasoning that disclosures related to fetal development and childbirth are related to the health of a woman seeking an abortion). Nor does the majority opinion offer any reasoned basis that might help apply its disclaimer for distinguishing lawful from unlawful disclosures. In the absence of a reasoned explanation of the disclaimer's meaning and rationale, the disclaimer is unlikely to withdraw the invitation to litigation that the majority's general broad "content-based" test issues. That test invites courts around the Nation to apply an unpredictable First Amendment to ordinary social and economic

regulation, striking down disclosure laws that judges may disfavor, while upholding others, all without grounding their decisions in reasoned principle.

Notably, the majority says nothing about limiting its language to the kind of instance where the Court has traditionally found the First Amendment wary of content-based laws, namely, in cases of viewpoint discrimination. "Content-based laws merit this protection because they present, albeit sometimes in a subtler form, the same dangers as laws that regulate speech based on viewpoint." *Reed,* 576 U. S., at ___ (ALITO, J., concurring) (slip op., at 1). Accordingly, "[l]imiting speech based on its 'topic' or 'subject' " can favor "those who do not want to disturb the status quo." *Ibid.* But the mine run of disclosure requirements do nothing of that sort. They simply alert the public about child seat belt laws, the location of stairways, and the process to have their garbage collected, among other things.

Precedent does not require a test such as the majority's. Rather, in saying the Act is not a longstanding health and safety law, the Court substitutes its own approach—without a defining standard—for an approach that was reasonably clear. Historically, the Court has been wary of claims that regulation of business activity, particularly health-related activity, violates the Constitution. Ever since this Court departed from the approach it set forth in *Lochner* v. *New York*, 198 U. S. 45 (1905), ordinary economic and social legislation has been thought to raise little constitutional concern. As Justice Brandeis wrote, typically this Court's function in such cases "is only to determine the reasonableness of the Legislature's belief in the existence of evils and in the effectiveness of the remedy provided." *New State Ice Co.* v. *Liebmann*, 285 U. S. 262, 286–287 (1932) (dissenting opinion); see *Williamson* v. *Lee Optical of Okla., Inc.*, 348 U. S. 483, 486–488 (1955) (adopting the approach of Justice Brandeis).

The Court has taken this same respectful approach to economic and social legislation when a First Amendment claim like the claim present here is at issue. See, *e.g., Zauderer* v. *Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U. S. 626, 651 (1985) (upholding reasonable disclosure requirements for attorneys); *Milavetz, Gallop & Milavetz, P. A.* v. *United States*, 559 U. S. 229, 252–253 (2010) (same); cf. *Central Hudson Gas & Elec. Corp.* v. *Public Serv. Comm'n of N. Y.*, 447 U. S. 557, 563–564 (1980) (applying intermediate scrutiny to other restrictions on commercial speech); *In re R. M. J.*, 455 U. S. 191, 203 (1982) (no First Amendment protection for misleading or deceptive commercial speech). But see *Sorrell* v. *IMS Health Inc.*, 564 U. S. 552 (2011) (striking down regulation of pharmaceutical drug-related information).

Even during the *Lochner* era, when this Court struck down numerous economic regulations concerning industry, this Court was careful to defer to state legislative judgments concerning the medical profession. The Court took the view that a State may condition the practice of medicine on any number of requirements, and physicians, in exchange for following those reasonable requirements, could receive a license to practice medicine from the State. Medical professionals do not, generally speaking, have a right to use the Constitution as a weapon allowing them rigorously to control the content of those reasonable conditions. See, *e.g.*, *Dent* v. *West Virginia*, 129 U. S. 114 (1889) (upholding medical licensing requirements); *Hawker* v. *New York*, 170 U. S. 189 (1898) (same); *Collins* v. *Texas*, 223 U. S. 288, 297–298 (1912) (recognizing the "right of the State to adopt a policy even upon medical matters concerning which there is difference of opinion and dispute"); *Lambert* v. *Yellowley*, 272 U. S. 581, 596 (1926) ("[T]here is no right to practice medicine which is not subordinate to the police power of the States"); *Graves* v. *Minnesota*, 272 U. S. 425, 429 (1926) (statutes "regulating

the practice of medicine" involve "very different considerations" from those applicable to "trades [such as] locomotive engineers and barbers"); *Semler* v. *Oregon Bd. of Dental Examiners*, 294 U. S. 608, 612 (1935) (upholding state regulation of dentistry given the "vital interest of public health"). In the name of the First Amendment, the majority today treads into territory where the pre-New Deal, as well as the post-New Deal, Court refused to go.

The Court, in justification, refers to widely accepted First Amendment goals, such as the need to protect the Nation from laws that "'suppress unpopular ideas or information'" or inhibit the "'marketplace of ideas in which truth will ultimately prevail.'" *Ante*, at 12–13; see *New York Times Co.* v. *Sullivan*, 376 U. S. 254, 269 (1964). The concurrence highlights similar First Amendment interests. *Ante,* at 2. I, too, value this role that the First Amendment plays—in an appropriate case. But here, the majority enunciates a general test that reaches far beyond the area where this Court has examined laws closely in the service of those goals. And, in suggesting that heightened scrutiny applies to much economic and social legislation, the majority pays those First Amendment goals a serious disservice through dilution. Using the First Amendment to strike down economic and social laws that legislatures long would have thought themselves free to enact will, for the American public, obscure, not clarify, the true value of protecting freedom of speech.

B

Still, what about this specific case? The disclosure at issue here concerns speech related to abortion. It involves health, differing moral values, and differing points of view. Thus, rather than set forth broad, new, First Amendment principles, I believe that we should focus more directly upon precedent more closely related to the case at hand. This Court has more than once considered disclosure laws

relating to reproductive health. Though those rules or holdings have changed over time, they should govern our disposition of this case.

I begin with *Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U. S. 416 (1983). In that case the Court considered a city ordinance requiring a doctor to tell a woman contemplating an abortion about the

> "status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information with respect to birth control, adoption, and childbirth[, and] . . . 'the particular risks associated with her own pregnancy and the abortion technique to be employed.'" *Id.,* at 442 (quoting Akron Codified Ordinances §1870.06(C) (1978)).

The ordinance further required a doctor to tell such a woman that "'the unborn child is a human life from the moment of conception.'" *Akron*, *supra,* at 444 (quoting Akron Codified Ordinances §1870.06(B)(3)).

The plaintiffs claimed that this ordinance violated a woman's constitutional right to obtain an abortion. And this Court agreed. The Court stated that laws providing for a woman's "informed consent" to an abortion were normally valid, for they helped to protect a woman's health. *Akron*, 462 U. S., at 443–444. Still, the Court held that the law at issue went "beyond permissible limits" because "much of the information required [was] designed not to inform the woman's consent but rather to persuade her to withhold it altogether." *Id.,* at 444. In the Court's view, the city had placed unreasonable "'obstacles in the path of the doctor upon whom [the woman is] entitled to rely for advice in connection with her decision.'" *Id.,* at 445 (quoting *Whalen* v. *Roe*, 429 U. S. 589, 604, n. 33

(1977)) (alteration in original).

Several years later, in *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U. S. 747 (1986), the Court considered a Pennsylvania statute that "prescribe[d] in detail the method for securing 'informed consent'" to an abortion. *Id.,* at 760. The statute required the doctor to tell the patient about health risks associated with abortion, possibly available benefits for prenatal care, childbirth, and neonatal care, and agencies offering alternatives to abortion. *Id.,* at 760–761. In particular it required the doctor to give the patient printed materials that, among other things, said:

> "'"There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or place her or him for adoption. The Commonwealth of Pennsylvania strongly urges you to contact them before making a final decision about abortion. The law requires that your physician or his agent give you the opportunity to call agencies like these before you undergo an abortion."'" *Id.,* at 761 (quoting 18 Pa. Cons. Stat. §3208(a)(1) (1982)).

The Court, as in *Akron*, held that the statute's information requirements violated the Constitution. They were designed "'not to inform the woman's consent but rather to persuade her to withhold it altogether.'" *Thornburgh*, *supra,* at 762 (quoting *Akron*, *supra,* at 444). In the Court's view, insistence on telling the patient about the availability of "medical assistance benefits" if she decided against an abortion was a "poorly disguised elemen[t] of discouragement for the abortion decision," and the law was the "antithesis of informed consent." *Thornburgh, supra*, at 763–764.

These cases, however, whatever support they may have

given to the majority's view, are no longer good law. In *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833 (1992), the Court again considered a state law that required doctors to provide information to a woman deciding whether to proceed with an abortion. That law required the doctor to tell the woman about the nature of the abortion procedure, the health risks of abortion and of childbirth, the "'probable gestational age of the unborn child,'" and the availability of printed materials describing the fetus, medical assistance for childbirth, potential child support, and the agencies that would provide adoption services (or other alternatives to abortion). *Id.,* at 881 (joint opinion of O'Connor, KENNEDY, and Souter, JJ.) (quoting 18 Pa. Cons. Stat. §3205 (1990)).

This time a joint opinion of the Court, in judging whether the State could impose these informational requirements, asked whether doing so imposed an "undue burden" upon women seeking an abortion. *Casey*, 505 U. S., at 882–883. It held that it did not. *Ibid.* Hence the statute was constitutional. *Id.,* at 874. The joint opinion stated that the statutory requirements amounted to "reasonable measure[s] to ensure an informed choice, one which might cause the woman to choose childbirth over abortion." *Id.,* at 883. And, it "overruled" portions of the two cases, *Akron* and *Thornburgh*, that might indicate the contrary. *Id.,* at 882.

In respect to overruling the earlier cases, it wrote:

> "To the extent *Akron I* and *Thornburgh* find a constitutional violation when the government requires, as it does here, the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus, those cases go too far, are inconsistent with *Roe*'s acknowledgment of an important interest in potential life, and are over-

ruled." *Ibid.*

The joint opinion specifically discussed the First Amendment, the constitutional provision now directly before us. It concluded that the statute did not violate the First Amendment. It wrote:

> "All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated, see *Wooley* v. *Maynard*, 430 U. S. 705 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State, cf. *Whalen* v. *Roe*, 429 U. S. 589, 603 (1977). We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here." *Casey*, 505 U. S., at 884.

Thus, the Court considered the State's statutory requirements, including the requirement that the doctor must inform his patient about where she could learn how to have the newborn child adopted (if carried to term) and how she could find related financial assistance. *Id.,* at 881. To repeat the point, the Court then held that the State's requirements did *not* violate either the Constitution's protection of free speech or its protection of a woman's right to choose to have an abortion.

C

Taking *Casey* as controlling, the law's demand for even-handedness requires a different answer than that perhaps suggested by *Akron* and *Thornburgh*. If a State can lawfully require a doctor to tell a woman seeking an abortion about adoption services, why should it not be able, as here, to require a medical counselor to tell a woman seeking

prenatal care or other reproductive healthcare about childbirth and abortion services? As the question suggests, there is no convincing reason to distinguish between information about adoption and information about abortion in this context. After all, the rule of law embodies evenhandedness, and "what is sauce for the goose is normally sauce for the gander." *Heffernan* v. *City of Paterson*, 578 U. S. ___, ___ (2016) (slip op., at 6).

1

The majority tries to distinguish *Casey* as concerning a regulation of professional conduct that only incidentally burdened speech. *Ante,* at 10–11. *Casey*, in its view, applies only when obtaining "informed consent" to a medical procedure is directly at issue.

This distinction, however, lacks moral, practical, and legal force. The individuals at issue here are all medical personnel engaging in activities that directly affect a woman's health—not significantly different from the doctors at issue in *Casey*. After all, the statute here applies only to "primary care clinics," which provide "services for the care and treatment of patients for whom the clinic accepts responsibility." Cal. Code Regs., tit. 22, §75026(a); see Cal. Health & Safety Code Ann. §§123471(a), 1204, 1206(h). And the persons responsible for patients at those clinics are all persons "licensed, certified or registered to provide" pregnancy-related medical services. Cal. Code Regs., tit. 22, §75026(c). The petitioners have not, either here or in the District Court, provided any example of a covered clinic that is not operated by licensed doctors or what the statute specifies are equivalent professionals. See, *e.g.*, App. to Pet. for Cert. 92a (identifying two obstetrician/gynecologists, a radiologist, an anesthesiologist, a certified nurse midwife, a nurse practitioner, 10 nurses, and two registered diagnostic medical sonographers on staff).

The Act requires these medical professionals to disclose information about the possibility of abortion (including potential financial help) that is as likely helpful to granting "informed consent" as is information about the possibility of adoption and childbirth (including potential financial help). That is why I find it impossible to drive any meaningful legal wedge between the law, as interpreted in *Casey*, and the law as it should be applied in this case. If the law in *Casey* regulated speech "only 'as part of the *practice* of medicine,'" *ante,* at 11 (quoting *Casey*, *supra,* at 884), so too here.

The majority contends that the disclosure here is unrelated to a "medical procedure," unlike that in *Casey*, and so the State has no reason to inform a woman about alternatives to childbirth (or, presumably, the health risks of childbirth). *Ante,* at 11. Really? No one doubts that choosing an abortion is a medical procedure that involves certain health risks. See *Whole Woman's Health* v. *Hellerstedt*, 579 U. S. ___, ___ (2016) (slip op., at 30) (identifying the mortality rate in Texas as 1 in 120,000 to 144,000 abortions). But the same is true of carrying a child to term and giving birth. That is why prenatal care often involves testing for anemia, infections, measles, chicken pox, genetic disorders, diabetes, pneumonia, urinary tract infections, preeclampsia, and hosts of other medical conditions. Childbirth itself, directly or through pain management, risks harms of various kinds, some connected with caesarean or surgery-related deliveries, some related to more ordinary methods of delivery. Indeed, nationwide "childbirth is 14 times more likely than abortion to result in" the woman's death. *Ibid.* Health considerations do not favor disclosure of alternatives and risks associated with the latter but not those associated with the former.

In any case, informed consent principles apply more broadly than only to discrete "medical procedures." Prescription drug labels warn patients of risks even though

taking prescription drugs may not be considered a "medical procedure." 21 CFR §201.56 (2017). In California, clinics that screen for breast cancer must post a sign in their offices notifying patients that, if they are diagnosed with breast cancer, their doctor must provide "a written summary of alternative efficacious methods of treatment," a notification that does not relate to the *screening* procedure at issue. Cal. Health & Safety Code Ann. §109277. If even these disclosures fall outside the majority's cramped view of *Casey* and informed consent, it undoubtedly would invalidate the many other disclosures that are routine in the medical context as well. *Supra,* at 3–4.

The majority also finds it "[t]ellin[g]" that general practice clinics—*i.e.,* paid clinics—are not required to provide the licensed notice. *Ante,* at 11. But the lack-of-information problem that the statute seeks to ameliorate is a problem that the State explains is commonly found among low-income women. See Brief for State Respondents 5–6. That those with low income might lack the time to become fully informed and that this circumstance might prove disproportionately correlated with income is not intuitively surprising. Nor is it surprising that those with low income, whatever they choose in respect to pregnancy, might find information about financial assistance particularly useful. There is "nothing inherently suspect" about this distinction, *McCullen* v. *Coakley*, 573 U. S. ___, ___ (2014) (slip op., at 15), which is not "based on the content of [the advocacy] each group offers," *Turner Broadcasting System, Inc.* v. *FCC*, 512 U. S. 622, 658–659 (1994), but upon the patients the group generally serves and the needs of that population.

2

Separately, finding no First Amendment infirmity in the licensed notice is consistent with earlier Court rulings. For instance, in *Zauderer* we upheld a requirement that

attorneys disclose in their advertisements that clients might be liable for significant litigation costs even if their lawsuits were unsuccessful. 471 U. S., at 650. We refused to apply heightened scrutiny, instead asking whether the disclosure requirements were "reasonably related to the State's interest in preventing deception of consumers." *Id.,* at 651.

The majority concludes that *Zauderer* does not apply because the disclosure "in no way relates to the services that licensed clinics provide." *Ante,* at 9. But information about state resources for family planning, prenatal care, and abortion *is* related to the services that licensed clinics provide. These clinics provide counseling about contraception (which is a family-planning service), ultrasounds or pregnancy testing (which is prenatal care), or abortion. Cal. Health & Safety Code Ann. §123471(a). The required disclosure is related to the clinic's services because it provides information about state resources for the very same services. A patient who knows that she can receive free prenatal care from the State may well prefer to forgo the prenatal care offered at one of the clinics here. And for those interested in family planning and abortion services, information about such alternatives is relevant information to patients offered prenatal care, just as *Casey* considered information about adoption to be relevant to the abortion decision.

Regardless, *Zauderer* is not so limited. *Zauderer* turned on the "material differences between disclosure requirements and outright prohibitions on speech." 471 U. S., at 650. A disclosure requirement does not prevent speakers "from conveying information to the public," but "only require[s] them to provide somewhat more information than they might otherwise be inclined to present." *Ibid.* Where a State's requirement to speak "purely factual and uncontroversial information" does not attempt "to 'prescribe what shall be orthodox in politics, nationalism,

religion, or other matters of opinion or force citizens to confess by word or act their faith therein,'" it does not warrant heightened scrutiny. *Id.,* at 651 (quoting *West Virginia Bd. of Ed.* v. *Barnette*, 319 U. S. 624, 642 (1943)).

In *Zauderer*, the Court emphasized the reason that the First Amendment protects commercial speech at all: "the value to consumers of the information such speech provides." 471 U. S., at 651. For that reason, a professional's "constitutionally protected interest in *not* providing any particular factual information in his advertising is minimal." *Ibid.* But this rationale is not in any way tied to advertisements about a professional's own services. For instance, it applies equally to a law that requires doctors, when discharging a child under eight years of age, to "provide to and discuss with the parents . . . information on the current law requiring child passenger restraint systems, safety belts, and the transportation of children in rear seats." Cal. Veh. Code Ann. §27363.5(a). Even though child seat belt laws do not directly relate to the doctor's own services, telling parents about such laws does nothing to undermine the flow of factual information. Whether the context is advertising the professional's own services or other commercial speech, a doctor's First Amendment interest in not providing factual information to patients is the same: minimal, because his professional speech is protected precisely because of its informational value to patients. There is no reason to subject such laws to heightened scrutiny.

Accordingly, the majority's reliance on cases that prohibit rather than require speech is misplaced. *Ante,* at 12–14. I agree that "'in the fields of medicine and public heath, . . . information can save lives,'" but the licensed disclosure *serves* that informational interest by requiring clinics to notify patients of the availability of state resources for family planning services, prenatal care, and abortion, which—unlike the majority's examples of norma-

tive statements, *ante,* at 13—is truthful and nonmisleading information. Abortion is a controversial topic and a source of normative debate, but the availability of state resources is not a normative statement or a fact of debatable truth. The disclosure includes information about resources available should a woman seek to continue her pregnancy or terminate it, and it expresses no official preference for one choice over the other. Similarly, the majority highlights an interest that often underlies our decisions in respect to speech prohibitions—the marketplace of ideas. But that marketplace is fostered, not hindered, by providing information to patients to enable them to make fully informed medical decisions in respect to their pregnancies.

Of course, one might take the majority's decision to mean that speech about abortion is special, that it involves in this case not only professional medical matters, but also views based on deeply held religious and moral beliefs about the nature of the practice. To that extent, arguably, the speech here is different from that at issue in *Zauderer*. But assuming that is so, the law's insistence upon treating like cases alike should lead us to reject the petitioners' arguments that I have discussed. This insistence, the need for evenhandedness, should prove particularly weighty in a case involving abortion rights. That is because Americans hold strong, and differing, views about the matter. Some Americans believe that abortion involves the death of a live and innocent human being. Others believe that the ability to choose an abortion is "central to personal dignity and autonomy," *Casey*, 505 U. S., at 851, and note that the failure to allow women to choose an abortion involves the deaths of innocent women. We have previously noted that we cannot try to adjudicate who is right and who is wrong in this moral debate. But we can do our best to interpret American constitutional law so that it applies fairly within a Nation whose citizens

strongly hold these different points of view. That is one reason why it is particularly important to interpret the First Amendment so that it applies evenhandedly as between those who disagree so strongly. For this reason too a Constitution that allows States to insist that medical providers tell women about the possibility of adoption should also allow States similarly to insist that medical providers tell women about the possibility of abortion.

D

It is particularly unfortunate that the majority, through application of so broad and obscure a standard, see *supra*, at 2–7, declines to reach remaining arguments that the Act discriminates on the basis of viewpoint. *Ante,* at 6, n. 2. The petitioners argue that it unconstitutionally discriminates on the basis of viewpoint because it primarily covers facilities with supporters, organizers, and employees who are likely to hold strong pro-life views. They contend that the statute does not cover facilities likely to hold neutral or pro-choice views, because it exempts facilities that enroll patients in publicly funded programs that include abortion. In doing so, they say, the statute unnecessarily imposes a disproportionate burden upon facilities with pro-life views, the very facilities most likely to find the statute's references to abortion morally abhorrent. Brief for Petitioners 31–37.

The problem with this argument lies in the record. Numerous *amicus* briefs advance the argument. See, *e.g.*, Brief for Scharpen Foundation, Inc., et al. as *Amici Curiae* 6–10; Brief for American Center for Law & Justice et al. as *Amici Curiae* 7–13. Some add that women who use facilities that are exempt from the statute's requirements (because they enroll patients in two California state-run medical programs that provide abortions) may still need the information provided by the disclosure, Brief for CATO Institute as *Amicus Curiae* 15, a point the majority adopts

in concluding that the Act is underinclusive, *ante,* at 15–16. But the key question is whether these exempt clinics are significantly more likely than are the pro-life clinics to tell or to have told their pregnant patients about the existence of these programs—in the absence of any statutory compulsion. If so, it may make sense—in terms of the statute's informational objective—to exempt them, namely if there is no need to cover them. See FACT Act, §1(d) (suggesting in general terms that this is so). But, if there are not good reasons to exempt these clinics from coverage, *i.e.,* if, for example, they too frequently do not tell their patients about the availability of abortion services, the petitioners' claim of viewpoint discrimination becomes much stronger.

The petitioners, however, did not develop this point in the record below. They simply stated in their complaint that the Act exempts "facilities which provide abortion services, freeing them from the Act's disclosure requirements, while leaving pro-life facilities subject to them." App. to Pet. for Cert. 104a. And in the District Court they relied solely on the allegations of their complaint, provided no supporting declarations, and contended that discovery was unnecessary. *Id.*, at 47a, 50a, 68a. The District Court concluded that the reason for the Act's exemptions was that those clinics "provide the entire spectrum of services required of the notice," and that absent discovery, "there is no evidence to suggest the Act burdens only" pro-life conduct. *Id.*, at 68a. Similarly, the petitioners pressed the claim in the Court of Appeals. *Id.*, at 20a–22a. But they did not supplement the record. Consequently, that court reached the same conclusion. Given the absence of evidence in the record before the lower courts, the "viewpoint discrimination" claim could not justify the issuance of a preliminary injunction.

II

The second statutory provision covers pregnancy-related facilities that provide women with certain medical-type services (such as obstetric ultrasounds or sonograms, pregnancy diagnosis, counseling about pregnancy options, or prenatal care), are not licensed as medical facilities by the State, and do not have a licensed medical provider on site. Cal. Health & Safety Code Ann. §123471(b)(1). The statute says that such a facility must disclose that it is not "licensed as a medical facility." §123472(b). And it must make this disclosure in a posted notice and in advertising. *Ibid.*

The majority does not question that the State's interest (ensuring that "pregnant women in California know when they are getting medical care from licensed professionals") is the type of informational interest that *Zauderer* encompasses. *Ante,* at 5, 17. Nor could it. In *Riley*, 487 U. S. 781, the Court noted that the First Amendment would permit a requirement for "professional fundraisers to disclose their professional status"—nearly identical to the unlicensed disclosure at issue here. *Id.*, at 799 and n. 11; see also *id.*, at 804 (Scalia, J., concurring in part and concurring in judgment) (noting that this requirement was not aimed at combating deception). Such informational interests have long justified regulations in the medical context. See, *e.g., Dent*, 129 U. S., at 122 (upholding medical licensing requirements that "tend to secure [a State's citizens] against the consequences of ignorance and incapacity, as well as of deception and fraud"); *Semler*, 294 U. S., at 611 (upholding state dentistry regulation that "afford[ed] protection against ignorance, incapacity and imposition").

Nevertheless, the majority concludes that the State's interest is "purely hypothetical" because unlicensed clinics provide innocuous services that do not require a medical license. *Ante,* at 17–18. To do so, it applies a searching

standard of review based on our precedents that deal with speech *restrictions*, not *disclosures*. *Ante,* at 17 (citing, *e.g., In re R. M. J.*, 455 U. S., at 203; *Virginia Bd. of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.*, 425 U. S. 748, 772, n. 24 (1976); *Bates* v. *State Bar of Ariz.*, 433 U. S. 350, 384 (1977); and *Zauderer*, 471 U. S., at 649 (portion of opinion considering speech restrictions, not disclosures)). This approach is incompatible with *Zauderer*. See *Zauderer*, *supra*, at 651 (upholding attorney disclosure requirements where "reasonably related to the State's interest"); *Milavetz*, 559 U. S., at 250–253 (same).

There is no basis for finding the State's interest "hypothetical." The legislature heard that information-related delays in qualified healthcare negatively affect women seeking to terminate their pregnancies as well as women carrying their pregnancies to term, with delays in qualified prenatal care causing life-long health problems for infants. Reproductive FACT Act: Hearing on Assembly B. 775 before the Senate Health Committee, 2015 Cal. Leg. Sess. Even without such testimony, it is "self-evident" that patients might think they are receiving qualified medical care when they enter facilities that collect health information, perform obstetric ultrasounds or sonograms, diagnose pregnancy, and provide counseling about pregnancy options or other prenatal care. *Milavetz*, *supra,* at 251. The State's conclusion to that effect is certainly reasonable.

The majority also suggests that the Act applies too broadly, namely, to all unlicensed facilities "no matter what the facilities say on site or in their advertisements." *Ante,* at 18. But the Court has long held that a law is not unreasonable merely because it is overinclusive. For instance, in *Semler* the Court upheld as reasonable a state law that prohibited licensed dentists from advertising that their skills were superior to those of other dentists. 294 U. S., at 609. A dentist complained that he was, in fact,

better than other dentists. *Id.*, at 610. Yet the Court held that "[i]n framing its policy, the legislature was not bound to provide for determinations of the relative proficiency of particular practitioners." *Id.*, at 612. To the contrary, "[t]he legislature was entitled to consider the general effects of the practices which it described, and if these effects were injurious in facilitating unwarranted and misleading claims, to counteract them by a general rule, even though in particular instances there might be no actual deception or misstatement." *Id.*, at 613.

Relatedly, the majority suggests that the Act is suspect because it covers some speakers but not others. *Ante,* at 18–19. I agree that a law's exemptions can reveal viewpoint discrimination (although the majority does not reach this point). "'[A]n exemption from an otherwise permissible regulation of speech may represent a governmental "attempt to give one side of a debatable public question an advantage in expressing its views to the people."'" *McCullen*, 573 U. S., at ___ (slip op., at 15) (quoting *City of Ladue* v. *Gilleo*, 512 U. S. 43, 51 (1994)). Such speaker-based laws warrant heightened scrutiny "when they reflect the Government's preference for the substance of what the favored speakers have to say (or aversion to what the disfavored speakers have to say)." *Turner Broadcasting System, Inc.*, 512 U. S., at 658. Accordingly, where a law's exemptions "facilitate speech on only one side of the abortion debate," there is a "clear form of viewpoint discrimination." *McCullen, supra,* at ___ (slip op., at 18).

There is no cause for such concern here. The Act does not, on its face, distinguish between facilities that favor pro-life and those that favor pro-choice points of view. Nor is there any convincing evidence before us or in the courts below that discrimination was the purpose or the effect of the statute. Notably, California does not single out pregnancy-related facilities for this type of disclosure requirement. See, *e.g.,* Cal. Bus. & Prof. Code Ann. §2053.6 (West

2012) (unlicensed providers of alternative health services must disclose that "he or she is not a licensed physician" and "the services to be provided are not licensed by the state"). And it is unremarkable that the State excluded the provision of family planning and contraceptive services as triggering conditions. *Ante,* at 18–19. After all, the State was seeking to ensure that "pregnant women in California know when they are getting medical care from licensed professionals," and pregnant women generally do not need contraceptive services.

Finally, the majority concludes that the Act is overly burdensome. *Ante,* at 19. I agree that "unduly burdensome disclosure requirements might offend the First Amendment." *Zauderer*, 471 U. S., at 651. But these and similar claims are claims that the statute could be applied unconstitutionally, not that it is unconstitutional on its face. Compare *New York State Club Assn., Inc.* v. *City of New York*, 487 U. S. 1, 14 (1988) (a facial overbreadth challenge must show "from actual fact" that a "substantial number of instances exist in which the Law cannot be applied constitutionally"), with *Chicago* v. *Morales*, 527 U. S. 41, 74 (1999) (Scalia, J., dissenting) (an as-applied challenge asks whether "the statute is unconstitutional as applied to *this* party, in the circumstances of *this* case"). And it will be open to the petitioners to make these claims if and when the State threatens to enforce the statute in this way. But facial relief is inappropriate here, where the petitioners "fail" even "to describe [these] instances of arguable overbreadth of the contested law," *Washington State Grange* v. *Washington State Republican Party*, 552 U. S. 442, 449–450, n. 6 (2008), where "[n]o record was made in this respect," and where the petitioners thus have not shown "from actual fact" that a "substantial number of instances exist in which the Law cannot be applied constitutionally," *New York State Club Assn.*, *supra*, at 14.

For instance, the majority highlights that the statute

requires facilities to write their "medical license" disclaimers in 13 languages. *Ante,* at 19. As I understand the Act, it would require disclosure in no more than two languages—English and Spanish—in the vast majority of California's 58 counties. The exception is Los Angeles County, where, given the large number of different-language speaking groups, expression in many languages may prove necessary to communicate the message to those whom that message will help. Whether the requirement of 13 different languages goes too far and is unnecessarily burdensome in light of the need to secure the statutory objectives is a matter that concerns Los Angeles County alone, and it is a proper subject for a Los Angeles-based as applied challenge in light of whatever facts a plaintiff finds relevant. At most, such facts might show a need for fewer languages, not invalidation of the statute.

* * *

For these reasons I would not hold the California statute unconstitutional on its face, I would not require the District Court to issue a preliminary injunction forbidding its enforcement, and I respectfully dissent from the majority's contrary conclusions.