Submission

on the

Health Amendment Bill 2019

to the

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Website: https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/current-inquiries/HealthLAB2019
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1. Introduction

On 28 November 2019, Hon Dr Steven Miles MP, Minister for Health and Minister for Ambulance Services, introduced the *Health Legislation Amendment Bill 2019*. The House referred the Bill to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee for detailed consideration. The committee is required to report by Friday 21 February 2020.

FamilyVoice Australia is a national Christian advocacy group – promoting family values for the benefit of all Australians. Our vision is to see strong families at the heart of a healthy society: where marriage is honoured, human life is respected, families flourish, Australia's Christian heritage is valued, and fundamental freedoms are valued and enjoyed.

We are independent of all political parties and engage with parliamentarians of all political persuasions.

Submissions close **Monday, 6 January 2020 at 12:00pm (midday).**

2. Terms of reference

The *Health Amendment Bill 2019*, inter alia, seeks to amend the *Public Health Act 2005* to prohibit the practice of "conversion" therapy by health service providers in Queensland.

3. Reason for this submission

In recent times, LGBT activists in this state and elsewhere have sought to ban any treatment or counselling by psychiatrists or others to help people who wish to change their sexual orientation.

This submission has been prompted by our concern for those seeking such treatment. Their opportunity for wellbeing has been put at risk by a political campaign that is not considering *the significant number* of people who wish to revert in their sexual orientation to heterosexual, whether that be from homosexuality or transgenderism.

The issues here are the right of a person to choose for themselves to revert to heterosexuality or their biological sex and the right of professionals to support their decision.

4. Testimony from a distinguished psychiatrist

Dr Joseph Berger, MBBS (hons) FRCPI DABPN, a Consulting Psychiatrist in Toronto and a Distinguished Life Fellow of the American Psychiatric Association, wrote a foreword to the 2013 book, *Beyond Critique: The Misuse of Science by UK Professional Mental Health Bodies*.[1] He said (in part):

> Two years after the 1969 Stonewall riots, some homosexuals protested vociferously at the annual meeting of the American Psychiatric Association (APA), claiming that psychiatry's designation of homosexuality as a mental disorder stigmatised and promoted discrimination against them.

The APA subsequently dropped this designation in order to reduce the stigma, and not because of the science. Indeed, many practising psychiatrists continued to protest that political pressures were not a good reason to change. Few, however, would have anticipated that the victims would become the persecutors. The outrageously unethical notion of banning psychotherapy for people who go voluntarily to a trained professional seeking to lessen their same-sex desires, even in order to marry or protect existing families, could not have been imagined.

But that is what therapists in the UK now face. The general public are unaware that activists have achieved such extreme restrictions without scientific justification.

I debated with Professor King and Mr Peter Tatchell recently in London, and was astonished to hear their weak arguments. Let it be understood very clearly:

1. There is a very large body of quality scientific literature demonstrating successful treatment of people unhappy with same-sex desires who became comfortably heterosexual. I referred to about 50 such publications.

2. There is no significant body of scientific literature demonstrating harm from such therapy, only some personal anecdotes.

3. "Sexual orientation" is a way of thinking about people's sexual preferences. There is no specific location in the brain for "sexual orientation" and no scientific justification to claim that a person with same-sex attraction cannot with psychotherapy discover – or re-discover – opposite sex attraction. If people who once identified themselves as heterosexual can in later life identify as homosexual, then the opposite must hold.

4. Despite 30 years of research and many well-publicised claims, there is no substantiated body of evidence that homosexuality is inherited genetically. Neither is there any scientific support for an anatomical (in the brain) biochemical, physiological, physical or organic cause. There is no scientific support for a recent speculative fantasy that homosexuality might be caused by uterine hormones on the foetus.

5. There is no physical or biological laboratory test to determine who is, and who isn't, homosexual. It is purely a self-identification.

The notion that a history of oppression justifies a gross interference with a process of treatment whose success has been demonstrated is absurd. Every ethical therapist offers psychotherapeutic help only to those who voluntarily seek it. In no other area of medicine or psychiatry would comparable client requests be denied. (End quote).

5. Ethical responsibilities of psychologists

Psychologists generally understand the main principles of modern therapeutic practice. Client autonomy, or self-determination is one, and informed consent is another.

In the leading academic journal *Psychotherapy*, and again in the *American Journal of Family Therapy*, Dr Mark Yarhouse of Regent University argues:

> *Psychologists have an ethical responsibility to allow individuals to pursue treatment aimed at curbing experiences of same-sex attraction ... not only because it affirms the clients' right to dignity, autonomy and agency ... but also because it demonstrates regard for diversity.*[2]

A 2012 statement by the Association of Christian Counsellors notes:

> *Any client seeking counselling has the right to indicate their goals and aspirations within counselling and to be respected for that choice. If a client seeks to explore change to their lifestyle or behaviour then using the core conditions the counsellor needs to respect that desire and work with them to their benefit. For the counsellor to reject this out of hand implies that they are seeking to impose their own agenda on the client and this is unethical.*[3]

The accepted principles of client autonomy and informed consent imply that people with unwanted same-sex attraction have a right to request help to change their orientation.

6. Sexuality and genetics

The American Psychological Association (APA) asserts:

> *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.*[4]

In fact, while there is significant evidence that genes play the major role in a person's biological sex, genes play little or no role in sexual orientation.

7. Twin studies

Some of the most important insights into the relative influence of genes and social environment on behaviour – nature and nurture – have come from twin studies. Since identical (or monozygotic) twins share the same genes, any genetic influence on one twin will be expressed equally in the co-twin. For example, since eye colour is genetically inherited, if one twin has blue eyes the co-twin will also have blue eyes. Recent twin studies have confirmed that identical twins have the same eye colour in almost 100% of cases.[5]

Why are some people sexually attracted to people of the same sex?

Several large scale twin studies have addressed the question of same-sex attraction in recent years, including: Bailey (2000);[6] Långström (2010)[7] and Burri (2011).[8] They have explored the influences of genes, family and life experiences.

All three studies found that the dominant influence on same-sex attraction is not genes, but unique life experiences – with estimates of the latter influence ranging from about 55% to 75%. In the Bailey and Långström studies, this was the *only* statistically significant influence found.

No study found any family influence, namely due to the twin's common social environment. The Burri study found a small but statistically significant heritability of 25%. How should this be interpreted? The influence could be genetic, or identical twins could influence each other towards same-sex attraction more than fraternal twins do.

What are the non-shared social environment factors that dominate the development of same-sex attraction?

All studies based on a comparison of identical twins and fraternal twins assume that the non-shared environment includes anything that individual twins experience differently. Even a shared home may be a non-shared environment, since parents may treat different children differently. A family event, such as divorce, may affect children differently. Children may experience different interactions with siblings, relatives, peers, schooling and the media.

One non-shared environment factor has been identified: significantly higher rates of childhood or adolescent homosexual molestation are reported among homosexual men and women than among heterosexuals.[9] For example, Dr Tomeo reported that 46% of the homosexual men surveyed were homosexually molested as a child, compared with 7% of heterosexual men. And 22% of lesbian women reported childhood homosexual molestation compared with 1% of heterosexual women. Homosexual abuse during childhood or adolescence seems to be one of the major influences on later adult same-sex attraction.

Homosexuality is not caused by genes or any one particular factor. Identical twins have the same genes, along with essentially the same exposure to maternal hormones in the womb that they share. But unlike eye colour, which has 100% concordance in identical twins, homosexuality has only about 10% concordance. It is clear that while life experiences – in some cases at a very early age – are involved, genes and hormones play a very minor part, if any.

Homosexuality is a human behaviour on par with other behaviours that are influenced by many differing environmental factors. Like those other behaviours – which may have been practised and reinforced over many years – change may be difficult. But if such a change is strongly desired, it is certainly not impossible and should not be prevented by legislation

8. What is ‘reparative therapy’?

The public conversation about conversion practices not infrequently refers to the rare examples of the use of electric shock treatment or other unacceptable forms of treatment. The assumption is that all reparative therapy is driven by homophobia.

This is not the case. For example, reparative therapy has become widely known since the 1990s through the work of US psychotherapist Dr Joseph Nicolosi.

- It is a “talking therapy” and doesn’t involve electric shocks
- It does not involve repressing sexual feelings, nor any kind of “trying” to be interested in the opposite sex.

Rather, patients who seek this therapy are encouraged to learn to connect with men as brothers, along with developing an unconditional self-acceptance. If and when changes in sexual orientation occur, they flow naturally as a consequence of overcoming shame issues around men, and feelings of “not fitting in” with men and one’s place in their world as equals.[10]

The term “reparative therapy” is often conflated or used interchangeably with “conversion” therapies, which have different origins and involve different processes.

Conversion therapy is based on discredited aversion-type behavioural therapies. It should not be confused with reparative therapy.[11] Legislating to prevent conversion therapy should not treat all therapy as discredited aversion-type behavioural therapies.

9. Can a person's sexuality change over time?

Overseas studies have shown that significant numbers of younger people change their sexual orientation over several years – mostly without therapy of any kind. These studies demonstrate very clearly that sexual orientation can be a fluid condition. Change is certainly possible for some people.

A 1997 study of Dutch adult males found that, of those who had experienced same-sex attraction at some stage of their lives, about half reported that those feelings disappeared later in life.[12]

A New Zealand cohort study found that one half of females and one third of males with occasional same-sex attraction at 21 years had only opposite-sex attraction at 26 years.[13]

Sexual attraction is particularly unstable in adolescents. US longitudinal research on adolescent health, using large scale surveys of 16, 17 and 22 year olds, revealed major changes in romantic attraction and sexual behaviour between those ages.[14] Of the boys who identified at 16 years as same-sex attracted, 72% were opposite-sex attracted by the age of 22 years – they had "discovered" girls. And of the same-sex attracted girls at 16 years, 55% were opposite-sex attracted by age 22.

The common claim that sexual orientation is fixed and unchangeable is a myth.

10. Why do some people seek to help change their sexual orientation?

There are several reasons why a person might wish to change their sexual orientation – and religious beliefs and avoiding stigma are not necessarily among them.

For both men and women, it may be a desire to procreate children in the natural way, and to share the raising of those children with their other natural parent.

Research shows that alcohol, tobacco smoking and drug abuse generally are disproportionately associated with the gay and lesbian community.[15] It is understandable that some men and women may wish to quit this environment in order to help end their addictions.

For men in particular, a wish to change orientation may be a desire to avoid the serious health consequences that are linked with the male homosexual lifestyle. ACON (originally known as the AIDS Council of NSW) has reported that almost all homosexual men have tried anal intercourse at least once, and about 80% say they have had anal intercourse during the past six months. Over 60% have performed "rimming" (anal-oral contact) during that time.[16]

These practices, which involve contact with harmful faecal pathogens, may seriously damage the health of participants – quite apart from the risk of HIV/AIDS transmission, of which the incidence in Australia is overwhelmingly among men who have sex with men.[17]

It is understandable that individuals may wish to explore the possibility of orientation change. The current campaign to deny them any possibility of such exploration is an outrageous breach of human rights.

11. Is reparative therapy harmful?

Despite claims by LGBT activists, there is no valid research showing that reparative therapy causes harm.

A 2002 study by Shidlo and Schroeder,[18] purporting to show such harm, was biased from the start. The researchers recruited subjects by asking: "Help us document the damage of homophobic therapies"!

Of around 200 men in this study, 23 said they had tried to kill themselves during their therapy, and 11 tried to do so after finishing therapy.

But the study did not prove that reparative therapy caused these serious consequences. No fewer than 25 participants had already attempted suicide before undergoing the therapy. A significant proportion of these men were psychologically very unstable.[19]

Indeed, *all* forms of therapy for *any* psychological condition carry some degree of risk of negative experiences. Extensive research has shown that 5-10% of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates – sometimes exceeding 20% – have been reported for children and adolescents in psychotherapy (Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013).[20]

Thus researchers would need to demonstrate reparative therapy deterioration rates significantly beyond 10% for adults and 20% for youth in order to substantiate harm. No such research exists.[21]

The American Psychological Association (APA) commissioned a task force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (SOCE).

The task force presented its report in 2009. It set out its methodology regarding the assessment of harm as follows:

> *Based on Lilienfeld's (2007) comprehensive review of the issue of harm in psychotherapy, our systematic review examines harm in the following ways:*
>
> - *Negative side effects of treatment (iatrogenic effects)*
> - *Client reports of perceptions of harm from treatment*
> - *High drop-out rates*
> - *Indirect harm such as the costs (time, energy, money) of ineffective intervention.*

The task force had been strongly criticised for its unbalanced composition – its membership only included those who subscribed to the view that SOCE were not "appropriate".

Nevertheless, the APA task force concluded that there was "a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE."[22]

Jones and Yarhouse say: "(W)e found little evidence of harm incurred as a result of the involvement of the participants in the Exodus change process. These findings would appear to contradict the

commonly expressed view of the mental health establishment that change of sexual orientation is impossible and that the attempt to change is highly likely to produce harm for those who make such an attempt.[23]

Valid research does not support claims that reparative therapy causes harm. The campaign against reparative therapy is driven not by evidence but by ideology.

12. Is reparative therapy beneficial?

Despite claims to the contrary, many studies show the benefits of reparative therapy for those who have sought it voluntarily, without pressure from family or church.

Dr Robert Spitzer was the leading psychiatrist involved in persuading the American Psychiatric Association to stop classifying homosexuality as a mental disorder in its diagnostic manual in 1973.

So Spitzer caused a huge sensation in 2001 when he presented a study showing that it was possible for some homosexual men and lesbians to change their orientation. In 2003 his study was published in a peer-reviewed journal, and reported the high satisfaction rate of the majority of reparative therapy participants.[24]

But in 2005 Spitzer reported that many of his colleagues were outraged by the publication of his research. There was tremendous anger in the gay community, which felt he had betrayed them by his "wrong" conclusions. Spitzer said he was suffering "battle fatigue" from the controversy.[25]

By 2012 his battle fatigue had grown to the point where Spitzer contacted his publisher to apologise for his earlier interpretation of his results.[26]

Nevertheless, Spitzer's study stands. It did not falsify data, nor did it analyse them incorrectly. Some critics have argued that since his research was carried out retrospectively, its results could be skewed by inaccurate memories of participants. But if all such data are deemed invalid, a great many studies would have to be discarded – including the Shidlo and Schroeder study mentioned in the previous section.

Dr Spitzer's experience of continued harassment and persecution, merely because his research results did not please the homosexual community, would have had a chilling effect on others thinking of investigating similar areas.

A longitudinal study by Jones and Yarhouse found "empirical evidence that change of homosexual orientation may be possible through involvement in Exodus ministries, either:

1. in the form of an embrace of chastity with a reduction in prominence of homosexual desire, or
2. in the form of a diminishing of homosexual attraction and an increase in heterosexual attraction with resulting satisfactory heterosexual adjustment.

"These latter individuals regard themselves as having changed their sexual orientation; the former regard themselves as having re-established their sexual identities to be defined in some way other than by their homosexual attractions."[27]

Jones and Yarhouse report that nearly every study ever conducted on change of orientation found some evidence of meaningful change.

They say: "The average positive outcome across these studies is about 30%, with another 30% or so 'in process'. While this is surely not a stunningly high rate of success, it is in line with the reported success rates for change attempts dealing with complex relational issues that are often faced in marital or family therapy, or the more difficult and stable psychological conditions. Also, the lack of sophisticated methodology does not prove the treatments failed; rather, it challenges researchers to provide more sophisticated program evaluations and outcome studies to clarify what clients can expect from various programs."[28]

13. Conclusion

- The evidence in this submission supports the view that the desire to revert to heterosexuality is not uncommon and should be respected in law and in society.
- Provided that a client has been fully informed of the nature and limitations of reparative therapy, and has voluntarily sought this treatment, his or her right to decide whether or not to proceed as an autonomous individual should be upheld by medical bodies and the Parliament.
- Given the absence of proven harm, and the clear evidence of beneficial outcomes in a significant number of cases, reparative therapy should be recognised as a valid option for those people who suffer distress because of unwanted sexual attractions, which are influenced far more by life experiences than genes or hormones.
- While questions of sexual orientation are deep and complex, as law recognises a person's right to choose an orientation other than their biological sex, law should not prevent a person choosing to revert to their biological sex and seek medical help to that end. This is an infringement on their human rights.
- Legislating to prevent conversion therapy should not treat all forms of therapy as discredited aversion-type behavioural therapies.

14. Endnotes

[1] Dermot O'Callaghan and Peter May, "Beyond Critique The Misuse of Science by UK Professional Mental Health Bodies", Core Issues Trust, UK, 2013.

[2] Eg: http://psycnet.apa.org/journals/pst/35/2/248/

[3] http://www.acc-uk.org/pdfs/BoardStatementDec2012.pdf

[4] http://www.apa.org/helpcenter/sexual-orientation.aspx

[5] Posthuma, Danielle, et al., 2006, "Replicated Linkage for Eye Color on 15q Using Comparative Ratings of Sibling Pairs", *Behavior Genetics*, Vol 36, No 1, pp 12-17; Zhu, G, et al., 2004, "A genome scan for eye color in 502 twin families: most variation is due to a QTL on chromosome 15q", *Twin Research*, Vol 7, pp 197‑210.

[6] http://faculty.wcas.northwestern.edu/JMichael-Bailey/Publications/Bailey%20et%20al.%20twins,2000.pdf

[7] Langstrom et al, 2010, "Genetic and Environmental Effects on Same-Sex Behavior: a Population Study of Twins in Sweden", *Archives of Sexual Behavior*, Vol 39, pp 75-80.

[8] Burri et al, 2011, "Genetic and Environmental Influences on Female Sexual Orientation, Childhood Gender Typicality, and Adult Gender Identity", *PLoS ONE*, Vol 6, Issue 7, e21982.

[9] Holmes W C, 1998, "Sexual Abuse of Boys Definition, Prevalence, Correlates, Sequelae, and Management", *Journal of the American Medical Association*, Vol 280, no 21, pp 1855-1962; Tomeo, M E, 2001, "Comparative Data of Childhood and Adolescence Molestation in Heterosexual and Homosexual Persons", *Archives of Sexual Behavior*, Vol 30, No 5, pp 1535-541; Eskin, M et al, 2005, "Same-Sex Sexual Orientation, Childhood Sexual Abuse, and Suicidal Behavior in University Students in Turkey", *Archives of Sexual Behavior*, Vol 34, No 2, pp 185-195.

[10] Davidson, Michael R. (2012), "The Right to Decide: Seeking justice for choices around unwanted same-sex attractions", *Core Issues Trust*.

[11] O'Callaghan, Dermot; Davidson, Michael (2013), "Out of Harm's Way: Working Ethically with Same-sex Attracted Persons", *Core Issues Trust*.

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[15] "Higher use of drugs, alcohol and tobacco in gay, lesbian and bisexual population", *Massey News*, Massey University, New Zealand, 1 July 2007.

[16] ACON fact sheet, "What sex do gay men have?": https://www.acon.org.au/mens-health/sex-and-sexual-wellbeing/What-Sex-Do-Gay-Men-Have

[17] *Cain, Michael v The Australian Red Cross Society 2009 TASADT 03*: http://www.magistratescourt.tas.gov.au/decisions/anti-discrimination_decisions/c/Cain_v_The_Australian_Red_Cross_Society_2009_TASADT_03

[18] Shidlo A & Schroeder M (2002), "Psychological treatments that cause harm", *Perspectives on Psychological Science*, Vol 2, pp 53-70.

[19] O'Callaghan, Dermot; Davidson, Michael (2013), "Out of Harm's Way: Working Ethically with Same-sex Attracted Persons", *Core Issues Trust*, p 14.

[20] www.core-issues.org/uploads/Davidson%20Letter%20of%20Support%20FINAL.pdf

[21] *Ibid.*

[22] O'Callaghan, Dermot; Davidson, Michael (2013), *loc cit*, p 12.

[23] Stanton L. Jones; Mark A. Yarhouse, 2011, "A Longitudinal Study of Religiously Mediated Sexual Orientation Change," *Journal of Sex & Marital Therapy*, Vol 37, Issue 5, pp 404-427.

[24] Robert L Spitzer, 2003, "Can Some Gay Men and Lesbians Change Their Sexual Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation", *Archives of Sexual Behavior*, Vol 32, No 5, pp 403-417; https://www.stolaf.edu/people/huff/classes/Psych130F2010/LabDocuments/Spitzer.pdf

[25] O'Callaghan, Dermot; Davidson, Michael (2013), *loc cit*, p 15.

[26] *Ibid, p 16.*

[27] Stanton L. Jones; Mark A. Yarhouse, 2011, "A Longitudinal Study of Religiously Mediated Sexual Orientation Change," *Journal of Sex & Marital Therapy*, Vol 37, Issue 5, pp 404-427.

[28] *Ibid*.