The Alliance and NARTH Institute Response to the WMA Statement on Natural Variations of Human Sexuality[1]

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[1] Retrieved from and available at http://www.narth.com/#!world-medical-association---narth/c4c6. Please note that since it was originally published, the name of the National Association for Research and Therapy of Homosexuality (NARTH) has been either replaced in the title and the text by "the Alliance for Therapeutic Choice and Scientific Integrity (Alliance) and NARTH Institute" or had "Institute" added, as appropriate.

The Alliance and NARTH Institute Response to the WMA

The Alliance for Therapeutic Choice and Scientific Integrity (Alliance) and NARTH Institute are greatly dismayed by the recent statement from the World Medical Association (WMA, 2013). The WMA statement is not so much a reflection on human sexuality as it is a clear attempt to discredit any and all professional attempts to assist clients who wish to modify same-sex attractions and behaviors. The Alliance and NARTH Institute observe that the WMA's statement in many places lacks scientific integrity, sometimes makes conclusions that are no more supportable than speculation, and at times fails to provide adequate scholarly context. Given these serious shortcomings, the Alliance and NARTH Institute believe it is necessary to provide the public with information that the WMA irresponsibly neglected in its statement.

The WMA states without equivocation that homosexuality is "without any intrinsically harmful health effects." This contention is exceedingly difficult to reconcile, for example, with a recent comprehensive review that found an overall 1.4% per-act probability of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer et al., 2012). These authors noted that "The 1.4% per-act probability is roughly 18-times greater than that which has been estimated for vaginal intercourse" (p. 5). In the United States in 2009, men having sex with men accounted for 61% of new HIV/AIDS diagnoses despite the fact that gay men are estimated to represent only 2–4% of the general population (Prejean et al., 2011; Savin-Williams & Ream, 2007). While such statistics may be influenced somewhat by stigma and discrimination, they appear to be ultimately grounded in biological reality. The Alliance and NARTH Institute are perplexed as to how the WMA could not consider such tragic medical effects as an intrinsic and harmful risk of male homosexual behavior.

While stigma and discrimination against gay and lesbian persons are important concerns with which mental health professionals ought to be concerned, the link between perceived discrimination and mental health outcomes is real, but the strength of this relationship is small (Pascoe & Richman, 2009). This means there is a great

deal more to be understood, and more moderating factors that may challenge current viewpoints need to be identified. For example, research into what influences the association between perceived discrimination and health outcomes has typically found no significant role for heretofore theoretically favored factors such as social support and identification with one's group. Similarly, constructs such as "internalized homophobia" may also be rapidly losing their explanatory utility (Newcomb & Mustanski, 2011). Findings also indicate that the incidence and type of psychological problems among gay and lesbian persons remains about the same whether they reside in tolerant and accepting environments or intolerant ones (Whitehead, 2010). This again suggests that our current understanding of the relationship between stigma and mental health outcomes may be far from definitive.

Worst of all, the WMA implies that professional psychological care to assist a client in modifying unwanted same-sex attractions and behaviors is a form of harm-inducing stigmatization and discrimination. The Alliance and NARTH Institute would kindly ask the WMA to provide the direct empirical basis for this supposition as well as a detailed list of the procedures NARTH Institute therapists engage in that allegedly exacerbate psychological distress. Since no study in existence disentangles preexisting client distress from any distress that may have occurred as a direct result of change-oriented psychological care, the Alliance and NARTH Institute believe the WMA statement in this regard has relied heavily on straw arguments. It certainly has not relied on the American Psychological Association's (2009) *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts* (SOCE), which had the honesty to acknowledge, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (p. 42). The WMA's clear dislike for a form of psychological care and its moral and theoretical assumptions, in the absence of definitive and replicated empirical evidence, is not a scientific basis for threatening medical and mental health professionals with "sanctions and penalties."

The WMA further fails to provide critical context for its unsubstantiated linking of change-oriented psychological care with psychological harm. Any discussion of alleged harms simply must be placed in the broader context of psychotherapy outcomes in general. Extensive research has shown that 5–10% of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates—sometimes exceeding 20%—have been reported for children and adolescents in psychotherapy (Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013). Deterioration rates would need to be established for professionally conducted change-oriented therapy significantly beyond 10% for adults and 20% for youth in order for claims of approach-specific harms to be substantiated. The Alliance and NARTH Institute assume the WMA knows that prevalence rates of success and harm for change-oriented psychological care are currently unknown, so it is difficult to avoid the conclusion that the WMA is targeting such care on ideological and not scientific grounds.

Finally, as the Alliance and NARTH Institute find frequently in statements of activism, the WMA creates straw arguments by claiming practitioners such as those aligned with the NARTH Institute view their work as attempting to "cure" homosexuality—when, in fact, most recognize that change usually takes place on a continuum of change, as is the case for nearly every other psychological and behavioral condition for which people seek professional care. Furthermore, the WMA's attempt to invalidate the psychological care of unwanted same-sex attractions and behaviors on the grounds that homosexuality is no longer considered to be a psychopathology or illness betrays a profound misrepresentation of the scope of psychotherapeutic practice. There are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy.

The experience of NARTH Institute clinicians is that, overwhelmingly, clients seek out their services due to moral and religious concerns, not because they consider

same-sex attractions and behaviors as a disease or psychopathology. In fact, clients pursue psychological care for many difficulties due to deeply held religious and moral beliefs (such as those stating that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention the WMA gives to change-oriented psychological care again hints at ideology rather than science as a primary motivation behind its statement.

The Alliance and NARTH Institute consider the WMA's recommendations to be an unacceptable encouragement of legislative or other intolerance and discrimination against sexual minorities who freely choose to receive help in order to overcome or diminish their unwanted sexual attractions, behaviors, and/or identity. This includes youth who themselves freely seek such services with the consent of their parents. Legislative or other intolerance and discrimination against medical and mental health practitioners, educators, and researchers is similarly unacceptable. The WMA would seek to prevent these professionals from offering their expertise to persons whose sexual minority concerns are unwanted and who, after being provided with informed consent, freely choose help in order to resolve, diminish, or manage them.

If enacted in any national or international jurisdiction, organizational intolerance and discrimination such as that recommended by the WMA would be a violation of human rights as recognized by the Universal Declaration of Human Rights (UDHR) (http://www.un.org/en/documents/udhr/index.shtml#a11) and the Convention on the Rights of the Child (CRC) (http://files.meetup.com/3480872/Convention%20on%20the%20Rights%20of%20the%20Child%20.pdf). These include the rights of both adults and children to: (1) the full development of one's human personality (UDHR, 26; cf., CRC, Preamble, 18 and 29); (2) medical care and necessary social services (UDHR, 25; cf. CRC, Preamble, 24, 27, and 39); (3) freedom of thought, conscience, and religion (UDHR, 18; cf., CRC, 14, 30); (4) education and freedom of opinion and expression, which includes the freedom to hold opinions without interference and to seek, receive,

and impart information and ideas through any responsible media (UDHR, 19; cf., CRC, 12, 13, and 17); and (5) the protection of the law against arbitrary interference with one's privacy or family and attacks on one's honor and reputation (UDHR, 12; cf., CRC, Preamble, 3, 5, 16, 29, 34, and 36).

These are but a few of the concerns that the Alliance and NARTH Institute have with the WMA statement, but they should be sufficient to illustrate the statement's deeply flawed and misleading portrayal of change-oriented psychological care. Additional relevant information can be obtained at the Alliance website (www.therapeuticchoice.com) and in the latest issue of the *Journal of Human Sexuality* (e.g., Rosik, 2013).

The Alliance and NARTH Institute believe the proper course of action for a truly professional organization given the current limited scientific base of knowledge regarding change-oriented psychological care should be to encourage further and ideologically diverse research. Instead, the WMA statement would infringe upon the rights and freedom of therapists and their clients with unwanted same-sex attractions and behaviors by creating a strict orthopraxy that is not grounded in definitive or properly contextualized empirical data. Within this orthopraxy, the WMA refuses to give its imprimatur to certain moral, religious, and theoretical views of homosexuality. It also restricts the range of options available for how clients with unwanted same-sex attractions and behaviors can therapeutically address their conflicts. The WMA statement thus appears to represent the rhetoric of heavy-handed activism and intimidation and is beneath the dignity of an organization that claims a professional and scientific identity.

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