Executive Summary: Health Impact Review of SB 5870

Prohibiting the Use of Aversion Therapy in the Treatment of Minors

Evidence indicates that SB 5870 has potential to mitigate harms and improve health outcomes among lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) patients, a population that is disproportionally impacted by poor health outcomes, thereby decreasing health disparities.

BILL INFORMATION

Sponsors: Representatives Liias, Litzow, Pedersen, Fain, Ranker, Rivers, Frockt, Cleveland, Mullet, Kohl-Welles, Keiser, Chase, Billig, Hasegawa, Darneille, Habib

Summary of Bill:

- Expands the list of acts that constitute unprofessional conduct by a licensed health care provider to include performing prohibited aversion therapies, including sexual orientation change efforts, on a patient under age 18.
- Defines "prohibited aversion therapy" as a practice, treatment or therapy involving sexual orientation change efforts, or electrical shock or extreme temperatures intended to cause pain, discomfort or unpleasant sensations to the client or patient, except electroconclusive therapies provided in accordance with guidelines set forward by the American Psychiatric Association and National Institute of Mental Health.
- Defines "sexual orientation change efforts" as any regimen that seeks to change an individual's sexual orientation—including efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. The definition does not include psychotherapies that promote acceptance, support, and understanding or facilitate coping, social support, and identity exploration, or provide interventions to address unlawful conduct or unsafe sexual practices, as long as they do not seek to change sexual orientation.

HEALTH IMPACT REVIEW

Summary of Findings:

This health impact review found the following evidence regarding the provisions in SB 5870:

- A fair amount of evidence that prohibiting the use of specific aversion therapies in the treatment of minors would decrease the risk of harm and improve health outcomes for LGBTQ patients.
- Very strong evidence that LGBTQ adults and youth disproportionately experience many negative health outcomes, and therefore mitigating any emotional, mental, and physical harm among this population has potential to decrease health disparities.

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Health Impact Review of SB 5870

Prohibiting the Use of Aversion Therapy in the Treatment of Minors

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Introduction and Methods

A health impact review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington state (RCW 43.20.285). For the purpose of this review 'health disparities' have been defined as the differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.270). This document provides summaries of the evidence analyzed by State Board of Health staff during the health impact review of Senate Bill 5870 (SB 5870).

Staff analyzed the content of SB 5870 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. Staff conducted objective reviews of the literature for each component of the pathway. Staff used databases including ERIC, PubMed, and Google Scholar to search the literature.

The following pages provide a detailed analysis of the bill including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength of the evidence for each relationship. The strength-of-evidence has been defined using the following criteria:

- **Not well researched:** the literature review yielded few if any studies or only yielded studies that were poorly designed or executed or had high risk of bias.
- **A fair amount of evidence:** the literature review yielded several studies supporting the association, but a large body of evidence was not established; or the review yielded a large body of evidence but findings were inconsistent with only a slightly larger percent of the studies supporting the association; or the research did not incorporate the most robust study designs or execution or had a higher than average risk of bias.
- **Strong evidence:** the literature review yielded a large body of evidence on the relationship (a vast majority of which supported the association) but the body of evidence did contain some contradictory findings or studies that did not incorporate the most robust study designs or execution or had a higher than average risk of bias; or there were too few studies to reach the rigor of 'very strong evidence'; or some combination of these.
- **Very strong evidence:** the literature review yielded a very large body of robust evidence supporting the association with few if any contradictory findings. The evidence indicates that the scientific community largely accepts the existence of the association.

Staff made modifications to these criteria at the start of the 2015 legislative session beginning January 12, 2015. Therefore strength-of-evidence rankings may not be comparable between reviews completed before and those completed after this date.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore the number of references included in the bibliography does not necessarily reflect the strength-of-evidence.

Analysis of SB 5870 and the Scientific Evidence

Summary of SB 5870

- Expands the list of acts that constitute unprofessional conduct by a licensed health care provider to include performing prohibited aversion therapies, including sexual orientation change efforts (SOCE), on a patient under age 18.
- Defines "prohibited aversion therapy" as a practice, treatment or therapy involving SOCE, or electrical shock or extreme temperatures intended to cause pain, discomfort or unpleasant sensations (except electroconclusive therapies provided in accordance with guidelines set forward by the American Psychiatric Association and National Institute of Mental Health).
- Defines "sexual orientation change efforts" as any regimen that seeks to change an individual's sexual orientation—including efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. The definition does not include psychotherapies that promote acceptance, support, and understanding; facilitate coping, social support, and identity exploration; or provide interventions to address unlawful conduct or unsafe sexual practices, that do not seek to change sexual orientation.

Health impact of SB 5870

Evidence indicates that SB 5870 has potential to mitigate harms and improve health outcomes among lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) patients, a population that is disproportionally impacted by poor health outcomes, thereby decreasing health disparities.

Pathways to health impacts

The potential pathways leading from SB 5870 to decreased health disparities are depicted in Figure 1. There is a fair amount of evidence that sexual orientation change efforts (SOCE) are associated with negative health outcomes such as depression, self-stigma, cognitive and emotional dissonance, emotional distress, and negative self-image.[1-7] The body of evidence may have been large enough to reach a 'strong' association, however the available studies did not use the most rigorous study designs. Research ethics make it difficult to rigorously study a practice associated with harm. To our knowledge, there are no studies examining the effects of sexual orientation change efforts on adolescents and youth.

Although a small number of studies have indicated that SOCE is associated with positive health outcomes (e.g. developing a sense of community), the evidence indicates that these positive outcomes are consistent with benefits offered by general mutual support groups. Therefore providing support groups within an affirmative and multiculturally competent framework could provide the same benefits without the potential negative health impacts of SOCE.[1,7] Moreover, there is little to no evidence that SOCE is associated with reduced same-sex attraction or increased other-sex attractions.[1-5] The American Psychological Association Ethics Code indicates that avoiding harm is an obligation of mental health providers and that in order for a treatment to be ethical it must both have evidence of efficacy and have no serious negative side effects.[1]

There is very strong evidence indicating that LGBTQ adults and youth disproportionately experience many negative health outcomes. For example, data indicate that LGBTQ youth are more likely to consider or attempt suicide; skip school because they feel unsafe; have property damaged or stolen while at school; and use alcohol, tobacco, and other illegal substances.[8-12] Mitigating any emotional, mental, and physical harm and improving health outcomes among this population therefore has potential to decrease health disparities.

Magnitude of impact

While the number of youth in Washington being subjected to aversion therapies as defined by SB 5870 is unknown, the literature indicates that large proportions of surveyed individuals who have been a part of SOCE report adverse health effects associated with these efforts. For example, in one study 37% of participants reported that SOCE was moderately or severely harmful for them and in another study 100% of participants reported stifling their authentic feelings as a result of SOCE.[2,6] These negative impacts can be severe and include self-reproach, depression, post-traumatic stress disorder, shame, guilt, and self-destructive behavior.[1-3,6-7]

Logic Model

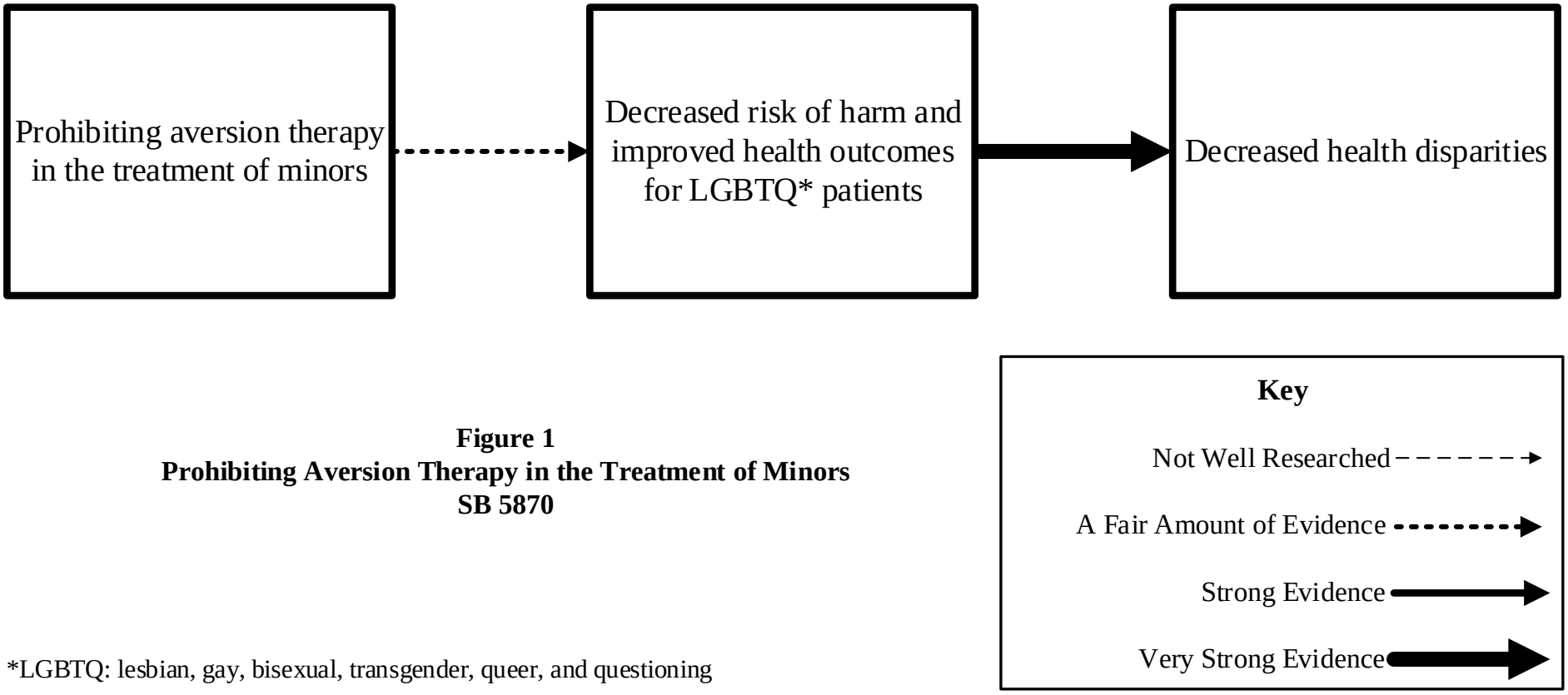

Figure 1
Prohibiting Aversion Therapy in the Treatment of Minors
SB 5870

*LGBTQ: lesbian, gay, bisexual, transgender, queer, and questioning

Summaries of Findings

Will prohibiting the use of specific aversion therapies in the treatment of minors decrease risk of harm and improve health outcomes for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) patient and youth?

Senate Bill 5870 defines "prohibited aversion therapy" to include: 1) sexual orientation change efforts (SOCE) or 2) using electrical shock or extreme temperatures intended to cause "pain, discomfort, or unpleasant sensations." Although we were not able to find any evidence specifically relating to harms associated with using electric shock and extreme temperatures as aversion therapy in children, the bill specifically applies to using these mechanisms to cause pain or discomfort, which by definition is considered harm.

There is also a fair amount of evidence that sexual orientation change efforts are associated with negative health outcomes such as depression, self-stigma, cognitive and emotional dissonance, emotional distress, and negative self-image. The published articles on the efficacy of SOCE have not stood up well against the scrutiny of the scientific community. Several researchers have conducted reviews of the literature on SOCE and have overwhelmingly concluded that the majority of these studies have serious methodological problems. When considering the body of literature as a whole (including strength of the studies and measured outcomes), most reviewers have concluded that there is little to no evidence that SOCE is associated with reduced same-sex attraction or increased other-sex sexual attractions, little evidence that there are positive health impacts associated with SOCE, and a fair amount of evidence that there are negative emotional, mental, and physical health outcomes associated with these interventions. In addition, researchers have indicated that the positive outcomes that some studies have found to be associated with SOCE are consistent with benefits observed from general mutual support groups (e.g. developing a sense of community). Therefore providing support groups within an affirmative and multiculturally competent framework could provide the same benefits without the potential negative health impacts of SOCE.

Will decreasing risk of harm and improving health outcomes for LGTBQ patients decrease health disparities?

There is very strong evidence indicating that LGBTQ adults and youth disproportionately experience many negative health outcomes. For example data indicate that LGBTQ youth are more likely to consider or attempt suicide; skip school because they feel unsafe; have property damaged or stolen while at school; use alcohol, tobacco, and other illegal substances; and have a high Body Mass Index (BMI). Data from the Washington State Healthy Youth Survey also indicate that students who are harassed at school due to their perceived sexual orientation (irrespective of how they actually identify) are also more likely to suffer from negative health outcomes such as substance use; homelessness; lower grades; and suicide contemplation or attempts. This measure does not directly indicate health disparities experienced by LGBTQ youth in Washington because these students did not self-identify but rather indicated that they had been harassed for being *perceived* as lesbian, gay, or bisexual. This measure does provide some important information though, such as insights into the social stigma, harassment, and discrimination that exist in Washington's schools in relation to sexual orientation, and the negative health outcomes that are associated with this stigma. Because LGBTQ youth and adults disproportionately experience many negative health outcomes, mitigating any emotional, mental, and physical harm among this population has potential to decrease these health disparities.

Annotated References

1. **American Psychological Association. Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. 2009. Available from http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf.**

The American Psychological Association established a Task Force on Appropriate Therapeutic Reponses to Sexual Orientation. The task force released a report in 2009 which presented findings from a review of the peer-reviewed literature on the psychotherapy and psychology of sexual orientation written between 1960 and 2007. The report indicates that a majority of the 83 studies evaluated had serious methodological problems. The task force concluded that there is little if any evidence that SOCE lead to reduced same-sex attraction or increased other-sex sexual attractions. In addition, the task force concluded that there is some evidence that individuals have experienced harm from SOCE. Some studies have found SOCE to be associated with negative health outcomes such as emotional distress and negative self-image, while other studies have found SOCE to be associated with positive outcomes such as developing a sense of community. The report indicates, though, that the positive outcomes identified are consistent with benefits observed from general mutual support groups. Therefore providing support groups within an affirmative and multiculturally competent framework could provide the same benefits while mitigating the harmful aspects of SOCE. The task force also reviewed the literature on the impact of SOCE on children and adolescents. They found that little research has been done in this area, and that the few studies that have been conducted found no evidence that psychotherapy for children impacts adult sexual orientation. They also raised concerns that these interventions could lead to self-stigma and stress among children and adolescents. The research indicates that SOCE for adolescents often do not present medically accurate information, are fear-based, and have potential to increase social stigma.

2. **Fjelstrom, J. Sexual orientation change efforts and the search for authenticity. *Journal of Homosexuality*. 2013; 60(6): 801-827.**

Fjelstrom conducted personal interviews using a structured interview guide (n=15). All participants had taken part in sexual orientation change efforts. The authors indicate that 100% of the participants expressed "suppressing and stifling their authentic feelings." Common themes identified through analysis of the interview transcripts were participants, "hiding their true feelings, trying to 'pass' as heterosexual, working hard to convince themselves that change was occurring, dissembling about their feelings to others, and separating themselves from portions of their identities." The researcher found that, among this group of participants, these therapy techniques were often offered by unlicensed counselors rather than licensed therapists. Many participants reported experiencing cognitive/emotional dissonance and self-reproach and feeling inferior, emotionally injured, hopeless, and shamed during and after going through sexual orientation change efforts. The limitations listed in the article include potential interviewer bias, the dependence on retrospective accounts, and the use of a convenience sample.

3. **Hein LC, Matthews AK. Reparative therapy: The adolescent, the psych nurse, and the issues. *Journal of Child and Adolescent Psychiatric Nursing*. 2010; 23(1): 29-35.**

Hein et al. conducted an in-depth literature review of evidence relating to sexual orientation change efforts. They did not identify any youth-based studies that had considered the effects of orientation change efforts. The researchers indicate that there is no conclusive empirical evidence that these approaches provide benefits to patients, and that a number of harmful consequences of these therapies on adults have been documented by former

patients as well as the literature. These negative impacts (as reported by the literature, statements by former patients and mental health providers, and case reports) include: anxiety, depression, avoidance of intimacy, sexual dysfunction, post-traumatic stress disorder, lack of self-confidence and self-efficacy, shame, guilt, self-destructive behavior, and suicidality.

4. **Karten EY, Wade JC. Sexual orientation change efforts in men: A client perspective. *Journal of Men's Studies*. 2010; 18(1).**

Karten et al. distributed surveys to 117 adult men who had recently participated in sexual orientation change efforts. The post-intervention survey asked participants to assess their changes in sexual and psychological functioning after the change effort. They found a statistically significant decrease in homosexual feelings and behavior and increase in heterosexual feelings and behavior. The researchers found that on average men reported positive changes in their psychological well-being, such as increased self-esteem, social functioning and decreased depression, self-harm behavior, and thoughts of and attempts at suicide. The authors acknowledged the following limitations of this study: the study was based on self-reported data that was collected at one point in time but that asked participants to assess feelings and behaviors at the current time and then at a point in time before they initiated the change therapy; participants may have exaggerated the changes due to social desirability or cognitive dissonance; the measures do not have extensive validation research and assessed changes in sexual behavior and feelings rather than changes in sexual orientation per se; there was no control group; and the findings were correlational in nature and causal relationships cannot be attributed to the variables.

5. **Serovich JM, Craft SM, Toviessi P, Gangamma R, McDowell T, Grafsky EL. A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy*. 2008; 34(2): 227-238.**

Serovich et al. conducted a systematic review of the literature on sexual orientation change therapy. They found 28 peer-reviewed articles that fit their inclusion criteria. The aim of this study was to analyze the strength of the studies conducted on this topic, not the findings of these studies. The researchers conclude that although many of these studies used ample sample sizes, most of the studies did not report essential information such as drop-out rate and participant demographics. Most of the studies also did not include control groups or long-term longitudinal follow-up. They conclude that the body of evidence on the efficacy of these therapeutic practices is lacking scientific rigor and that this calls into question the validity of interventions based on a "flawed empirical database."

6. **Bradshaw K, Dehlin JP, Crowell KA, Galliher RV, Bradshaw WS. Sexual orientation change efforts through psychotherapy for LGBQ individuals affiliated with the Church of Jesus Christ of Latter-day Saints. *Journal of Sex & Marital Therapy.* 2014:1-22.**

Bradshaw et al. conducted a survey of current and former members of the Mormon church who had experienced various types of therapies to address same-sex attraction. Of the 1,612 adults surveyed 93 reported experiencing aversion therapy practices, and 465 reported experiencing psychotherapy where the primary goal was sexual orientation change. Of these participants who experienced some type of sexual orientation change effort, 79% rated their experience as not effective at all (42%), moderately harmful (21%), or severely harmful (16%). Less than 4% reported any change in sexual attraction.

7. **Flentje A, Heck NC, Cochran BN. Experiences of ex-ex-gay individuals in sexual reorientation therapy: reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*. 2014;61(9):1242-1268**

Flentje et al. conducted a qualitative survey of open-ended questions with 38 adults recruited via snowball sampling and the internet. Participants met the inclusion criteria if they had been through any kind of psychotherapy aimed at changing their sexual orientation from lesbian, gay, or bisexual to heterosexual. The 38 participants provided information on 113 episodes of sexual orientation change therapy sessions. Researchers analyzed survey responses for short and long term benefits and harms associated with the therapy as reported by the survey participants. Eighteen percent of therapy visits were classified by participants as providing a sense of connectedness and support. Thirty one percent of therapy episodes were classified as not helpful in the long-term. The most commonly reported short-term harms included predictors of anxiety and depression, with 15% of therapy episodes classified as provoking shame and guilt. Twenty-one percent of therapy episodes were reported to have no long-term harms, while 18.6% were reported to cause long term guilt, shame and self-hatred.

8. **Balsam KF, Beadnell B, Riggs KR. Understanding sexual orientation health disparities in smoking: A population-based analysis. *American Journal of Orthopsychiatry*. 2012; 82(4): 482-493.**

Balsam et al. analyzed Washington State Behavioral Risk Factor Surveillance System data from 2003 to 2007. Survey participants were asked to indicate whether they consider themselves to be 'heterosexual,' 'homosexual,' or 'bisexual, or something else.' Respondents who recorded 'other' or 'don't know/not sure' were excluded from analysis. The researchers found that respondents who self-identified as lesbian, gay, or bisexual were more likely to smoke cigarettes. The researchers conducted modeling in order to identify protective factors and risk factors for smoking. They found that psychological distress and life dissatisfaction were risk factors for lesbian, gay, and bisexual populations. They point to other research which has found higher levels of anxiety and depression among LGBTQ individuals. Balsam et al. found that alcohol use is a risk factor for smoking, and they also pointed to previously published evidence that alcohol use rates are higher among LGBTQ populations. They also found tobacco marketing targeted at LGBTQ communities as well as single relationship status were risk enhancers for smoking. Note that the researchers also identified protective factors among lesbian, gay, and bisexual participants such as higher education levels. In addition, there are trends that are unique to subpopulations (such as different risk or protective factors for bisexual women than for lesbian women), so the researchers are careful not to generalize findings that are unique to specific subpopulations.

9. **Duncan DT, Hatzenbuehler ML. Lesbian, gay, bisexual, and transgender hate crimes and suicidality among a population-based sample of sexual-minority adolescents in Boston. *American Journal of Public Health*. 2013; 5.**

Duncan and Hatzenbuehler analyzed 2008 Boston Youth Survey data for 9th through 12th graders. They aggregated data from all students who self-identified as 'mostly heterosexual,' 'bisexual,' 'mostly homosexual,' 'gay or lesbian,' or 'unsure.' The researchers found that LGBTQ adolescents were more likely to contemplate and attempt suicide than their heterosexual peers. Nearly one third of LGBTQ adolescents reported suicidal ideation in the past year compared to 9.43% of heterosexual youth. They also found that LGBTQ youth who contemplated or attempted suicide were more likely to live in neighborhoods with higher LGBTQ assault hate crimes.

10. Healthy Youth Survey. QxQ Analysis. 2012. Accessed February 3, 2014. Available from http://www.askhys.net/Analyzer.

Data from the 2012 Washington State Healthy Youth Survey indicate that almost 12% of 8th grade students, nearly 11% of 10th grade students, and about 7% of 12th students have been harassed at school due to perceived sexual orientation. These students (regardless of how they actually identify) are significantly more likely than their peers who have not been subjected to such harassment to experience more risk factors and negative health outcomes. For example, youth who are harassed for being perceived as gay, lesbian, or bisexual are more likely to be currently using alcohol, cigarettes, marijuana, or other illegal drugs; are more likely to have been involved in a physical fight at school; are less likely to be living with their parents (e.g. are homeless, living in a shelter, living with friends); have lower grades; and are more likely to suffer from depression and to contemplate or attempt suicide. Note that this information only indicates the existence of an association between harassment based on perceived sexual orientation and these negative health outcomes and does not indicate causation. This basic analysis of the data did not control for confounding factors. In addition, the Healthy Youth Survey does not collect information on sexual orientation as self-identified by the student, but only collected data on whether or not a student had been harassed for their perceived sexual orientation. The data indicate, though, that students who reported being bullying in general (although they also saw worse health outcomes than their peers who did not report being bullied) were not as likely to experience many of these negative outcomes as students that were bullied specifically about their perceived sexual orientation. For example, 7.0% (± 1.6) of 12th grade students who reported that they were not bullied in the past 30 days were living with someone aside from their parents and 11.5% (± 3.8) of 12th graders who reported being bullied in the past 30 days were living with someone other than a parent, while 43.5% (± 9.6) of the 12th graders who reported being harassed due to their perceived sexual identity in the past 30 days were living with someone other than a parent. This measure may provide some insight into the social stigma, harassment, and discrimination that exists in Washington's public schools in relation to sexual orientation, and the negative health outcomes that are associated with this harassment.

11. Rosario M, Corliss HL, Everett BG, et al. Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: Pooled Youth Risk Behavior Surveys. *American Journal of Public Health*. 2013; 3.

Rosario et al. analyzed Youth Risk Behavior Survey (YRBS) data for 14 of the 15 jurisdictions in the United States that conduct these surveys and collect data on sexual orientation (n=65,871). They defined sexual orientation using survey questions relating to sexual attractions, gender of sexual partners, or sexual identity. In addition, they classified any student who indicated that they were uncertain of their sexual identity as having same-sex orientation. The researchers found that youth who indicated same-sex orientation reported more cancer-related risk behaviors than did heterosexual students. For example, youth who indicated same-sex orientation were more likely to have a high BMI and to use substances such as alcohol, cigarettes, and other tobacco products.

12. Russell ST, Everett BG, Rosario M, Birkett MA. Indicators of victimization and sexual orientation among adolescents: Analyses from Youth Risk Behavior Surveys. *American Journal of Public Health*. 2013; 2.

Russell et al. analyzed YRBS data from 13 jurisdictions that collect YRBS surveys and measured either sexual orientation identification or gender of sexual partners (n=48,879).

The data revealed that students who reported same-sex orientation in their identity or behavior were significantly more likely to report fighting, skipping school because they felt unsafe, and having property damaged or stolen while at school. LGBTQ youth also reported higher scores on indicators of victimization. The researchers also point out nuanced differences in outcomes between subpopulations of LGBTQ youth, indicating that it is important to consider the unique needs and experiences of each subpopulation.