Testimony to the Committee on Health Coverage, Insurance and Financial Services

Wednesday April 10, 2019

Re: LD 1025, An Act To Prohibit the Provision of Conversion Therapy to Minors by Certain Licensed Professionals

Representative Tepler, Senator Sanborn and members of the Committee, my name is Henry Skinner, MD. On behalf of the Maine Association of Psychiatric Physicians (of which I am President) and the Maine Council of Child and Adolescent Psychiatry (Secretary) and Tri-County Mental Health Services (Medical Director), I offer the following testimony. Both State organizations, as per their national organizations, have longstanding, evidence-based positions against so-called "conversion therapies," including "reparative therapy" and therefore strongly support passage of LD 1025.

The American Psychiatric Association published a position statement in March of 2000, in which it stated: "Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, the American Psychiatric Association recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm. The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. Therefore, the American Psychiatric Association opposes any psychiatric treatment such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual orientation."

The American Academy of Child and Adolescent Psychiatry in 2012 published an article in its journal, Journal of the American Academy of Child and Adolescent Psychiatry, stating: "Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful. There is no empirical evidence adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness and caring, important protective factors

against suicidal ideation and suicide attempts. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated." In 2018 they updated their position with a formal statement that I included with my original testimony.

The standard assessment of a proposed healthcare intervention is the randomized controlled trial (RCT). This involves assigning subjects in, random order, to either the new intervention or a comparison or control condition. In the case of a psychotherapeutic intervention, the generally accepted control condition is a waitlist. Outcome data (both benefits and harms) are collected systematically. Results are published in a peer-reviewed journal. To date, the number of randomized controlled trials of conversion and/or reparative "therapy" is ZERO. Anecdotal evidence and survey results indicate that the most likely outcome of such a trial would demonstrate harms significantly outweighing benefits. There isn't any data about how such "therapy" affects minors.

What we do know about LGBTQ youth is that a rejecting family environment raises their risk of suicide attempt 8.4-fold, their risk of severe depression 5.4-fold, and their risk of substance abuse and unprotected sex by 3.4-fold.

We also know that LGBTQ youth raised in accepting family and community environments have the same rates of mental health concerns as their cis/straight peers.

In no way would passage of LD 1025 prevent the treatment of any diagnosable mental health condition in a minor. Thousands of youth already receive effective, evidence-based mental health care every year in this state without any attempt to alter the course of their psychosexual development. There are at least 18 evidence-based therapy programs for trauma in children, according to the National Child Traumatic Stress Network. None of them involve efforts to change the client's sexual orientation or gender identity.

The State has a legitimate interest in ensuring that the mental health professionals whom it licenses provide safe and effective care to its residents. Overwhelming evidence supports the conclusion that conversion/reparative "therapy" does not meet these criteria.

In response to those who may be concerned that LD 1025 is an infringement on parental rights, it should be noted that it is already well established that society, through the auspices of Child Protective Services offices in every state, has an interest in preventing parents from harming children physically, verbally, sexually and emotionally. Conversion therapy is emotionally harmful.

On behalf of Maine's psychiatrists, I urge you to vote "Ought to Pass," to halt the exposure of Maine's most vulnerable children to fraudulent and harmful practices.

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