Oppose "Conversion Therapy" Ban

Dear Legislator,

PLEASE CONSIDER THIS EVIDENCE: Right to Happiness (5 pp. + endnotes)

(1) The Supreme Court of the United States said professional therapists have the same right to freedom of speech as everyone else. It abrogated decisions of the 9th and 3rd Circuit Courts that have been erroneously referenced to claim therapy bans are constitutional.[1] The 11th Circuit Court overturned therapy bans in its jurisdiction.[2]

(2) We urge you to oppose a "conversion therapy' ban bill. Protect the right to therapy. A view that unwanted sexual attraction or unwanted incongruent gender identity cannot safely or effectively decrease or change through standard therapies is generally based on 3 claims: (1) a scientifically abandoned view that same sex attraction and incongruent gender identity are inborn and unchangeable—they are who a person biologically is, like sex or skin color. Therefore, any attempt to change them would be doomed to failure and would only shame and harm people when they did not change. (2) Societal and therapeutic affirmation of LGBT experiences and discouraging treatment of any predisposing trauma or disorders improves the mental health and dignity of LGBT identified people. (3) A therapy goal of change is phobic, harmful, and ineffective. **We will now show that research contradicts these claims.**

SAME SEX SEXUALITY AND INCONGRUENT GENDER IDENTITY ARE NOT INBORN AND THEY CAN CHANGE

(3) Same-sex sexuality and incongruent gender identity are not biologically determined. A gene study, by more than 20 researchers in 7 nations, of nearly half a million people found same-sex behavior is **influenced somewhat by genes but largely by life experience in the environment.**[3] A global consensus statement of endocrine societies worldwide says there is **no consistent evidence brains are different for gender incongruent or congruent people.** Masculine and feminine aspects of the brain mostly develop gradually from life experiences. Gender identity develops from a complex interaction of "biopsychosocial" influences[4] [5] [6]**—like other unchosen, complex traits therapists help people decrease or change every day.**

(4) The American Psychological Association's *APA Handbook of Sexuality and Psychology*[7] and research say family factors[8] [9] [10] and childhood sexual abuse[11] may be causal factors in having same-sex partners for some, and family pathology[12] [13] may be a causal factor for transgender identity. Some clients want to explore these causes and heal.
<u>There is no reason why this therapy should be less safe or effective than any other therapy.</u>

(5) International research finds that psychiatric disorders and suicidality usually <u>EXIST BEFORE</u> onset of gender incongruence, therefore may cause it.[14]

- **An 8 year study of 8.8 million people found** 71% to 75% of gender incongruent adolescents (ages 10 to 17) had psychiatric disorders in their lifetime (similar rates in many countries[15]) <u>BEFORE</u> gender incongruence (also found in Finland[16]), compared to 3% to 4% of sex accepting peers. In the 6 months <u>BEFORE</u> first medical evidence of gender incongru-

ence, depression was 23 to 24 times higher than for gender congruent peers, suicidal ideation 45 to 54 times higher, and self-injuring behavior 70 to 144 times higher.[17]

- **Finland’s research[18] [19] and “Recommendation" say psychiatric disorders and suicidality may predispose to gender dysphoria[20]** in agreement with the World Professional Assoc. for Transgender Health,[21] American Psychiatric Assoc.,[22] and British Psychological Society.[23]
- **Psychiatric disorders also cause 90% of suicides worldwide.[24] Treating predisposing psychiatric disorders may resolve both suicides and gender dysphoria.**
- **Activists appear unaware that these conditions do not come after therapy but before it, therefore change-exploring therapy does not cause them.**

(6) They can change.

- The *APA Handbook of Sexuality and Psychology* and robust research internationally have established that same-sex attraction, romantic partnerships, behavior, and identity all commonly shift or change for adolescents and adults, men and women.[25] [26] [27]
- Gender dysphoria overwhelmingly resolves for children—85-90%[28] and changes lifelong.[29]

SOCIETAL AND THERAPEUTIC AFFIRMATION OF LGBT FEELINGS AND EXPRESSIONS AND DISCOURAGING ANY THERAPY FOR UNDERLYING CAUSES HAS NOT HELPED LGBT HEALTH, MENTAL HEALTH, OR SUICIDES

(7) Living as the opposite sex[30] and puberty blockers[31] stop natural resolution of gender dysphoria in children, sending them down an experimental and body harming medical path. **Cross sex hormones and surgeries *sterilize children,* reduce sexual pleasure[32], and lead to** 2 to 2.5 times higher rates of deaths from cancers, strokes, and heart attacks, and a 19 times higher rate of completed suicides[33] [34] [35]. Long term, it is *not* transgender health and *not* suicide prevention.[36] Yet psychiatric hospitalizations still persist at a nearly 3 times higher rate.

- Under therapy bans, youths who regret transition cannot be helped to embrace their body sex.
- **Gender services in some countries that have the longest experience with treating gender dysphoria are strongly going in the direction of restricting medical affirmative treatments for minors**—Finland and Sweden.[37]

(8) *Finland’s gender dysphoria treatment “Recommendation” for minors says “first-line treatment” should include aiming to reduce or resolve gender dysphoria by aiming to reduce or resolve predisposing disorders, and not changing bodies.[38] This is exactly what change-exploring therapy does and bans would criminalize. Yet therapy ban activists are promoting medical interventions for gender incongruence and criminalizing therapy that treats underlying disorders. This is a disaster.*

(9) Replacing change therapy with affirmative treatment has not helped.

- The largest study in the Netherlands found that nearly half a century—45 years—of progressively increasing societal affirmation and gender affirmative treatments for gender incongruent adolescents and adults has resulted in little to no change in their higher suicide rates.[39] Parent support for transitioning minors does not help, contrary to claims.[40]
- During 50 years of progressively and dramatically increasing societal affirmation of LGB identity, affirmative therapy, and discouragement of any change therapy that treats potential

underlying sexual or gender trauma, LGB psychological stress has progressively worsened, according to the originator of the minority stress theory and colleagues.[41]

- ***Exactly what therapy bans require—increasing affirmative treatments and criminalizing treatments for underlying disorders or trauma—has not decreased suicides.***

Therapy ban activists are misguiding lawmakers to take exactly the wrong direction.

THERE ARE RATIONAL REASONS WHY PEOPLE WANT CHANGE EXPLORING THERAPY. CLAIMING MOTIVES TO CHANGE MUST BE PHOBIC OR COERCED IS ITSELF STIGMATIZING AND PHOBIC.

(10) Here are 5 common reasons people desire change:

- (1) They found living as LGBT **unfulfilling.**
- (2) They feel their LGBT feelings were forced on them by sexual or gender trauma and do not represent their authentic self. They want the **right to heal.**
- (3) **They want to reduce risky sexual or gender behavior and the desire to engage in it.** Risky behavior may include behavior that is unhealthy, unsafe to self, others, one's marriage, or family, unlawful, unfulfilling, a symptom of trauma or a psychiatric disorder, or undesirable for whatever reason a person chooses. People should have the right to therapeutic help to reduce or change these behaviors and the desire to engage in them without requiring government approval of their reasons, and regardless of whether they are directed toward the *opposite* sex or the *same* sex, or are gender *congruen*t or gender *incongruent*, *without discrimination*.
- (4) **They want to live according to the faith of their heart that should be respected**. Robust research[42] [43] and studies by a team of LGBT-affirming and change-affirming researchers show that LGBT people who live according to their traditional faith are no less happy, mentally healthy, satisfied with life, and flourishing than those of liberal faith or no faith.[44] Harm studies generally exclude them because they do not use an LGBT identity. They find change therapy substantially more helpful. A cultural change in ideology is not required.
- (5) **They aspire to be in—and want to reduce same sex attraction to be faithful in—an opposite sex marriage.** For some, incongruent gender identity or expression is putting their marriage and family at risk. The *APA Handbook of Sexuality and Psychology* says, "contrary to the conventional wisdom," most people who are same sex attracted are both sex attracted. They are "the norm," and exclusive same sex attraction is "the exception."[45] Research says their relationships are mostly opposite sex[46] and satisfying.[47]

Change-allowing therapy helps to keep LGBT families safe.

RESEARCH SUPPORTS THAT CHANGE EXPLORING THERAPY IS SAFE AND EFFECTIVE. CLAIMS BASED ON IGNORANCE OF THIS RESEARCH ARE NOT ACCEPTABLE.

(11) Research examples of safe and effective therapy and faith-based support:

- **A ban will criminalize LGB-affirmative therapists for saving lives.** LGB affirmative researchers demonstrated in **several replicated, randomized, controlled trials** that men can lastingly decrease casual same sex behavior through standard therapies to reduce HIV transmission risk and protect health.[48] Some bans forbid help to decrease same sex behavior. It is wrong, harmful, and absurd to criminalize saving lives.

- **A two-year, prospective, longitudinal study found that men significantly decreased same sex attraction expressions, significantly increased opposite sex attraction expressions, and significantly changed sexual attraction identity in the heterosexual direction** through Reintegrative Therapy®, a specific form of change exploring therapy that enjoys certain legal protections in the US. **Well-being significantly and clinically improved with a strong effect.**[49]
- **In another study, sex, sexual ideation, desire for same-sex intimacy, and kissing decreased toward the same sex and increased toward the opposite sex. More than two-thirds (69%) of men decreased same-sex attraction. Many were married (41%), nearly all with children—on average 3 children each. The number of married men engaging in same-sex behavior before therapy was 71% and plunged to 14% after therapy. What this means to these men, their wives, and their children can hardly be expressed. For them and the participants overall, depression and suicidality significantly decreased, and self esteem significantly increased.** Psychological benefits greatly outweighed any harms. (professional therapy and/or faith-based care; convenience sample; 88% religious)[50]
- **A majority of people in faith-based ministries (53%) substantially decreased or changed their same-sex attraction, and psychosocial functioning only improved,** as documented by **a rigorous "naturalistic, quasi-experimental, longitudinal study".**[51]
- **Comprehensive research reviews by gay-affirming[52] and change-affirming[53] researchers both accept that research participants report they changed same-sex attraction and behavior** through non-aversive, standard therapies. These reviews **agree there is no research that meets scientific standards that proves non-aversive, change-exploring therapy is unsafe or ineffective.** US federal district[54] and 11th Circuit[55] courts agree.

(12) Change-exploring therapy actually reduces suicidality for both minors and adults who do *not* successfully change same sex attraction through therapy, and dramatically—17 to 25 times lower—for adults, according to a replicated study. But Blosnich and colleagues hid this. This research used a US nationally representative set of data of LGB-identified people created by gay-affirming researchers. The data set gives rates of participants' suicidal thoughts, plans, intent, or attempts both before and after therapy. Blosnich and colleagues (2020) intentionally used only the after therapy suicidality rates, then claimed therapy caused them. But Sullins (2021) replicated the study using both before and after therapy suicidality rates and found suicidality decreased after therapy. "Most of the suicidality did not follow change-exploring therapy in time but preceded it." Unsurprisingly, people who were suicidal got therapy more than people who were not suicidal. The therapy decreased their suicidality.

- **Harm-claiming studies regularly make this mistake: Blaming therapy for depression and suicidal symptoms that preceded it is like saying people who have had anti-depressant medication have had more depression and suicidality than people who have not sought anti-depressants. Therefore anti-depressants cause depression and suicidality and should be banned. This is blaming the cure,** a tragic, misguided mistake that will bring about the very harm activists aim to prevent.[56] This kind of mistake is a violation the principle of the scientific method that a cause must precede an effect in time, and it is well-known to be research malpractice. But it is a ploy claim-harming studies use regularly.
- **Activists in professional organizations use this kind of dishonest research to guide their boards to make position statements about change-exploring therapy.** The Ameri-

can Psychological Assoc. says it bases its statement on Blosnich and colleagues and other studies like it.[57] [58] [59] [60] [61] [62] [63] [64] Many organizations follow the APA.

- **Therapy ban bills base themselves on this dishonest research and on these organization position statements based on the same dishonest research.**

(13) An American Psychological Association task force (2009): (i) Said aversive methods have not been used for 40-50 years.[65] (ii) Said it based its recommendations on one-sided, anecdotal, not scientific, evidence.[66] (iii) Said it based its recommendations on “key findings in the research” that included that same-sex attraction does not change through life experiences[67] and that is now corrected by the *APA Handbook of Sexuality and Psychology* (2014).[68]

(14) Many professional organizations world-wide affirm change-exploring therapy.[69] There is not a professional consensus against change-exploring therapy.[70]

- Several organizations[71] and governments[72] find the “best available” research for medical gender affirmation practices is very poor.
- **Many UN nations reject the mandate and therapy-opposing report of an individual “expert”;[73] no UN binding agreement mentions sexual orientation or gender identity.**
- **Professional organizations that acknowledge there can be pathological causes for LGBT experiences for some and reject therapy that changes these experiences by treating underlying causes are in a state of internal contradiction and are contradicted by other organizations and the Finland Recommendation. They do not have a professional consensus.**

CONCLUSION

(15) Government should not decide who someone is, what will make a person happy, and who may have access to family or life saving conversations. Everyone should have the right to walk away from sexual or gender practices and experiences that do not work for them and have help to live the way that brings them health and happiness. We urge you to vote “NO” on a “conversion therapy” ban bill.

Respectfully submitted by the National Task Force for Therapy Equality

See endnotes for references and information to answer questions.
(Updates maintained at: TherapyEquality.org/HarmsOfTherapyBans)
Testimonies of change at footnote:[74]

Endnotes:

[1]National Institute of Family and Life Advocates v. Becerra, 138 S.Ct. 2361, 2018, p. 14.

More on legal decisions related to therapy regarding sexual orientation and gender identity:

1. The Supreme Court of the United States (SCOTUS) rendered a decision (National Institute of Family and Life Advocates v. Becerra, 2018) that professional speech has the same right to freedom of speech as any other speech. SCOTUS said it has never accepted a doctrine that professional speech is professional conduct and therefore can be censored. Otherwise, all the government would need to do to take away first amendment rights from a group of people would be to license them.

2. This decision specifically abrogated previous decisions in the 9th (Pickup et al. v. Brown, 2013) and 3rd (King v. Governor of the State of New Jersey, 2014) Circuit Courts of Appeals that had previously been used to argue to legislators that therapy bans are Constitutional. It is often reported that SCOTUS declined appeals to hear these decisions in 2013 and omitted that SCOTUS abrogated them in 2018.

3. A decision of the US 11th Circuit Court of Appeals struck down conversion therapy ban laws (Otto et al. v. City of Boca Raton et al, 2020) based in part on the SCOTUS decision (NIFLA v Becerra, 2018).

4. The Council of Europe, which also includes all EU Member States, guarantees freedom of speech and freedom of religion, the latter of which includes the right to hold, share, and manifest religious beliefs and faith.

5. A United Kingdom High Court in Bell vs. Tavistock (Dec. 12, 2020) ruled that medical gender affirming treatment in minors was experimental and could not, in most cases, be given to minors under 16 without court order, and that such was advisable for those 16-17. They added, “There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.” (Bell et al. v. GIDS, UK, 2020, https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf)

[2] Otto, et al v. City of Boca Raton, FL et al:
Press release: https://lc.org/newsroom/details/112020-court-of-appeals-strikes-down-fl-counseling-ban-1
The legal decision: https://lc.org/PDFs/Attachments2PRsLAs/112020Otto.pdf

[3] Genetics of Sexual Behavior: A website to communicate and share the results from the largest study on the genetics of sexual behavior, https://geneticsexbehavior.info/what-we-found/ ;based on: Ganna, A., et al. (2019). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior, Science 365, eaat7693 (2019). DOI: 10.1126/science. aat7693, https://geneticsexbehavior.info/wp-content/uploads/2019/08/ganna190830.pdf

[4] (Repeats another footnote.)
At least 14 professional organizations agree, transgender identity has social environment causes. It is not simply biologically caused by genes, hormones, or brain structures.

Quotes and Summaries of Statements

The Endocrine Society and 6 organizations that co-sponsored its Guideline: the American Association of Clinical Endocrinologists, American Society of Androlgy, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, World Professional Association for Transgender Health:
“Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression likely reflect a complex interplay of biological, environmental, and cultural factors.” Endocrine Society Guideline (2017), pp. 6-7.
Hembree, W. et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology and Metabolism, 102, 1–35. https://doi.org/10.1210/jc.2017-01658

Consensus Statement: Global DSD Consortium 2016 Update (6 endocrine societies): European Society for Pediatric Endocrinology, Pediatric Endocrine Society, Asian Pacific Pediatric Endocrine Society, Japanese Society of Pediatric Endocrinology, Sociedad Latino-Americana de Endocrinologia Pediatrica, Chinese Society of Pediatric Endocrinology and Metabolism
Quote is in another footnote.
Lee, P.A., et al. (2016). Consensus Statement: Global disorders of sex development update since 2006: Perceptions, approach and care. *Hormone Research in Pediatrics, 85*, 158–180. https://doi.org/10.1159/000442975

The American Psychological Association’s *APA Handbook of Sexuality and Psychology* says transgender identity is not simply biologically determined, has psychological causes, and may be pathological. Affirmative treatment may neglect individual problems gender dysphoric minors are experiencing.
APA Handbook of Sexuality and Psychology (2014), *1*: 743-744, 750.

American Psychiatric Association’s DSM-5: “[I]n contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development.” (DSM-5, p. 451) “Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.” (DSM-5, pp. 451 457).
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. 451, 457.

American Academy of Pediatrics: Gender identity “results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions.”
Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness (2018), Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents. *Pediatrics 142(4)*: pp. 2, see also p. 4, e20182162

Some organizations are in more than one organizations group above.

[5] Identical twins share the same genes and biological environment in the womb before birth. This means they share potential or hypothesized biological influences on sexual attraction or gender identity or expression—such as genes, epigenetics, prenatal hormones, prenatal maternal factors, and number of older brothers (hypothesized by some to influence prenatal factors). Identical twins are always the same sex. Sex is biologically determined. But if one identical twin comes to have LGB experiences, incongruent gender identity, or LGB experiences and incongruent gender expression, the other usually does not. This shows that *non*biological influences—influences *other than* genes or prenatal biological environmental conditions—are predominant causal factors for LGB attraction and behavior and incongruent gender identity and expression..

Bailey et al. (2016): LGB experiences: pp. 74-76. Non conforming gender expression: pp. 46, 76.
Incongruent gender identity: Diamond, M. (2013). Transsexuality among twins: Identity concordance, transition, rearing, and orientation, *International Journal of Transgenderism, 14:*1, 24-38,(Print) 1434-4599 (Online) Journal homepage: http://www.tandfonline.com/loi/wijt20 Journal homepage: http://www.tandfonline.com/loi/wijt20

[6] Gender incongruence is not caused by having the brain of the opposite sex.

The Global DSD Consortium Consensus Statement Update 2016 (a highly respected consensus statement of endocrine societies around the world) says,

- No consistent evidence that brain structures are different for gender *incongruent* people and gender *congruent* people.
- Masculine or feminine aspects of the brain largely develop “gradually” (after birth),
- In interaction with *psychological*, social, and cultural experiences in the environment.

(European Society for Paediatric Endocrinology, Paediatric Endocrine Society, Asian Pacific Paediatric Endocrine Society, Japanese Society of Paediatric Endocrinology, Sociedad Latino-Americana de Endocrinologia Paediatrica, Chinese Society of Paediatric Endocrinology and Metabolism. (Lee et al., 2016))

[7] The American Psychological Association gave its “imprimatur" to its *APA Handbook of Sexuality and Psychology* and declared it “authoritative.” The series preface says,

“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.”

Gary R. VandenBos
APA Publisher

Vandenboss, G. (2014), Series Preface, in Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology, 1*: xvi, Washington D.C.: American Psychological Association, http://dx.doi.org/10.1037/14193-000

[8] LGBTQ IDENTIFIED ADOLESCENTS REPORTED HIGHER RATES OF CHILDHOOD ADVERSE EVENTS.

Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. Pediatrics, 141(5): e20173004. http://pediatrics.aappublications.org/content/early/2018/04/12/peds.

- LGBTQ youth were more likely to have grown up with household dysfunction defined by parent incarceration, problem drinking, or abuse of illegal or prescription drugs. This is included in both the household dysfunction and polyvictimization patterns.
- But not significant for Q youth, p. 3.

- LGBTQ youth were more likely to experience psychological and/or physical abuse that may have included witnessing domestic violence (p. 4) and polyvictimization that adds household dysfunction and sexual abuse.

- Gender nonconforming adolescents, especially bisexuals, had experienced more types of abuse. Transgender identity, especially for boys, was associated with more kinds of adverse experiences (household dysfunction, physical and/or sexual abuse, and polyvictimization, p. 6).

- Sexual orientation and gender identity may be generally confounded with gender nonconformity. However, this study specifically measured gender nonconformity separately and controlled for it, making it possible to discover that the association between LGBTQ youth and adverse experiences is not simply explained by gender nonconformity. pp. 6-7.

- Gender nonconforming adolescents (especially bisexual and transgender identified) had experienced more types of adverse experiences. Gender nonconformity, however, was not the only explanation for adverse experiences (p. 7). It is possible that greater adverse childhood experiences led to both gender nonconformity and LGBTQ identity.

[9] The American Psychological Association’s *APA Handbook of Sexuality and Psychology* says,

*“*Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies [largely includes family experiences] are evident as main effects [stand alone factors] or in interaction with biological factors….A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful.” (1:583)

Rosario, M. & Schrimshaw, E. (2014). Chapter 18: Theories and etiologies of sexual orientation. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). *APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches.* Pp. 555-596. Washington D.C.: American Psychological Association.https://www.apa.org/pubs/books/4311512

[10] Absence of a parent, especially the parent of the same-sex as the child, is a small but statistically significant and potentially causal factor found internationally for same-sex attraction, behavior, and marriage found in several large, robust, population-based, prospective, longitudinal studi below.
The first 6 years of life for both sexes and adolescence for girls may be sensitive periods (Frisch & Hviid, 2006).

Fergusson, D., Horwood, L., Beautrais, A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56*:p. 878.
Francis, A. M. (2008). Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. *Journal of Sex Research, 45* (4):371-377. http://www.tandfonline.com/doi/full/10.1080/00224490802398357?scroll=top&needAccess=true
Frisch, M. & Hviid, A. (2006). Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes. *Archives of Sexual Behavior, 35, pp.* 533-547. https://link.springer.com/article/10.1007/s10508-006-9062-2
Frisch, M. & Hviid, A. (2007). Reply to Blanchard’s (2007) “Older-sibling and younger-sibling sex ratios in Frisch and Hviid’s (2006) national cohort study of two million Danes.” Arch Sexual Behavior, 36, 864-867. https://link.springer.com/article/10.1007/s10508-007-9169-0
Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same- sex and opposite-sex interest. *Journal of Biosocial Science, 37:*481–497. http://dx.doi.org/10.1017/S0021932004006765

[11] The *APA Handbook of Sexuality and Psychology* says childhood sexual abuse has "associative and potentially causal links” to ever having same same partners. (1:609-610)

*"*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 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). To help control for possible confounding factors, the authors con- ducted post hoc analyses controlling for number of lifetime sexual partners and sex work, but the asso- ciation remained. The effect in women was smaller (odds ratio = 2.11) and a statistical trend (*p* = .09).” (1:609)

Mustanski, B., Kuper, L., and Geene, G. (2014). Chapter 19: Development of sexual orientation and identity. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches. Pp. 597-628. Washington D.C.: American Psychological Association. (“Sexual Abuse”, pp. 609-610.) https://www.apa.org/pubs/books/4311512

Wilson, H. & Widom, C. (2010). Does physical abuse, sexual abuse, or neglect in childhood increase the likelihood of same-sex sexual relationships and cohabitation? A prospective 30-year follow-up, *Archives of Sexual Behavior, 39*:63-74, DOI 10.1007/s10508-008-9449-3

[12] TRANSGENDER IDENTITY AFFIRMATION IN CHILDREN MAY BE HARMFUL:
The American Psychological Association’s *Handbook of Sexuality and Psychology* says affirming children to live as another sex may neglect individual problems gender dysphoric minors are experiencing.
APA Handbook of Sexuality and Psychology (2014), vol. 1, pp. 743-744, 750.

[13] This footnote duplicates information from another footnote.
Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. Pediatrics, 141(5): e20173004. http://pediatrics.aappublications.org/content/early/2018/04/12/peds .

- LGBT youth were more likely to have grown up with household dysfunction defined by parent incarceration, problem drinking, or abuse of illegal or prescription drugs. This is included in both the household dysfunction and polyvictimization patterns.
- But not significant for Q youth, p. 3.

- LGBTQ youth were more likely to experience psychological and/or physical abuse that may have included witnessing domestic violence (p. 4) and polyvictimization that adds household dysfunction and sexual abuse.

- Gender nonconforming adolescents, especially bisexuals, had experienced more types of abuse. Transgender identity, especially for boys, was associated with more kinds of adverse experiences (household dysfunction, physical and/or sexual abuse, and polyvictimization, p. 6).

- Sexual orientation and gender identity may be generally confounded with gender nonconformity. However, this study specifically measured gender nonconformity separately and controlled for it, making it possible to discover that the association between LGBTQ youth and adverse experiences is not simply explained by gender nonconformity. pp. 6-7.

- Gender nonconforming adolescents (especially bisexual and transgender identified) had experienced more types of adverse experiences. Gender nonconformity, however, was not the only explanation for adverse experiences (p. 7). It is possible that greater adverse childhood experiences led to both gender nonconformity and LGBTQ identity.

[14] Prevalence of psychiatric conditions (psychiatric disorders, neurodevelopmental disabilities, self injury, and suicidal thoughts) in gender incongruent adolescents and adults similar to the 75% range have been found in other US studies, 6 European countries, Canada, Australia, New Zealand, Japan and, and Iran. Most studies do not tell us whether the psychiatric conditions or the gender incongruence comes first. The Becerra-Culqui study in the US and the Kaltiala-Heino study in Finland tell us these high rates of psychiatric conditions came before gender incongruence.Therefore, psychiatric conditions may be causal for gender incongruence.

Becerra-Culqui T.A., Liu Y., Nash R., Cromwell, L., Flanders, W.D., Getahun, D., Giammattei, S.V., Hunkeler, E.M., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Sandberg, D.E., Silverberg, M.J., Tangpricha, V., & Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics, 141(5):e20173845. https://doi.org/10.1542/peds.2017-3845
Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health, 9, 4-6. https://doi.org/10.1186/s13034-015-0042-y

[15] **Research in many countries (examples listed below) has found gender incongruent/dysphoric adolescents and adults have similar high rates, often around the 75% range, of psychiatric conditions (psychiatric disorders, neurodevelopmental disabilities, self injury, and suicide)**. Most studies do not tell us what comes first, but Becerra-Culqui et al. (2018) in the US and Kaltiala-Heino et al. (2015) in Finland found evidence that **these psychiatric conditions precede gender incongruence/dysphoria. Therefore, these psychiatric conditions may be predisposing or causal factors. Since these conditions come before gender incongruence/dysphoria and change-exploring therapy, change exploring therapy cannot cause them.**

US: Becerra-Culqui et al., 2018, https://pubmed.ncbi.nlm.nih.gov/30476120-letter-to-the-editor-endocrine-treatment-of-gender-dysphoricgender-incongruent-persons-an-endocrine-society-clinical-practice-guideline/; Lipson et al., 2019, https://pubmed.ncbi.nlm.nih.gov/31427032/ ; Hanna et al., 2019, https://www.sciencedirect.com/science/article/abs/pii/S1047279719302832?via%3Dihub ; Rider et al., 2018, https://pediatrics.aappublications.org/content/pediatrics/141/3/e20171683.full.pdf ; Littman, 2018, https://doi.org/10.1371/journal.pone.0202330 ;

Finland: Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health, 9, 4-6. https://doi.org/10.1186/s13034-015-0042-y

Netherlalnds, Belgium, Germany, Norway: Heylens, G., Baudewijntje, E.E., Kreukels, P.C., Paap, M.C.S., Cerwenka, S., Richter-Appelt, H., Cohen-Kettenis, P.T., Haraldsen, I.R., & De Cuypere, G. (2014), https://doi.org/10.1192/bjp.bp.112.121954

Finland: Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and Lindberg, N. (2015).https://doi.org/10.1186/s13034-015-0042-y

Sweden: Salmi, P. (Feb. 2020). Utvecklingen av diagnosen
könsdysfori: Förekomst, samtidiga psykiatriska diagnoser och dödlighet i suicid, National Board of Health and Welfare, Sweden, http://www.socialstyrelsen.se/

Canada: Bechard, M., VanderLaan, D.P., Wood, H., Wasserman, L., & Zucker, K.J. (2017). https://doi.org/10.1080/0092623X.2016.1232325 Australia: Strauss et al., 2017, https://www.telethonkids.org.au/globalassets/media/documents/brain--behaviour/trans-pathways_plain-text_no-figures.pdf ;

Australia: Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. (2017).https://www.telethonkids.org.au/globalassets/media/documents/brain--behaviour/trans-pathways_plain-text_no-figures.pdf

New Zealand: Veale, J., Byrne, J., Tan, K., Guy, S., Yee, A., Nopera, T., & Bentham, R. (2019). https://researchcommons.waikato.ac.nz/bitstream/handle/10289/12942/Counting%20Ourselves_Report%20Dec%2019-Online.pdf?sequence=54&isAllowed=y

Japan: Hoshiai M., Matsumoto Y., Sato T., Ohnishi M., Okabe N., Kishimoto Y., Terada S., Kuroda S. (2010). Psychiatric comorbidity among patients with gender identity disorder. *Psychiatry and Clinical Neurosciences, 64(5),* 514-519. https://europepmc.org/article/MED/20727112

Iran: Meybodi, A.M., Hajebi, A., & Jolfaei, A.G. (2014a). Psychiatric Axis I comorbidities among patients with gender dysphoria, *Hindawi Publishing Corporation Psychiatry Journal, 14,* Article ID 971814 (5 pp). https://www.researchgate.net/publication/265254861_Psychiatric_Axis_I_Comorbidities_among_Patients_with_Gender_Dysphoria
Taken together with:
Meybodi, A.M., Hajebi,A., & Jolfaei, A.G. (2014b). The frequency of personality disorders in patients with gender identity disorder. *Medical Journal of the Islamic Republic of Iran, 28.90*, 6 pp. https://www.academia.edu/39292966/

[16] In Finland, 75% of adolescents applying for medical gender affirming interventions had severe psychiatric disorders in their lifetime that commonly began before, and seldom after, they questioned their gender identity, according to their medical records.

In addition, the majority of adolescent applicants had been significantly bullied at school (57%), in nearly every case *before* they questioned their gender identity (92%) and for reasons unrelated to gender presentation or gender identity (73%). In nearly half the adolescents applying for gender services (49 percent), persistent experiences of bullying *before* thoughts about gender was found to be associated with peer isolation, anxiety, depression, self-harm, and suicidal preoccupation, if not attempts. These adolescents had very high hopes that sex change procedures would solve all their social, academic, and mental health problems (Kaltiala-Heino et al., 2015, pp. 4-6). We have treatments for psychiatric disorders, neurodevelopmental disabilities, and suicidal thoughts, and we are making continual advances. Those who are promoting experimenting on children’s bodies are showing stunning disinterest in what is causing children and adolescents to reject their bodies and in offering non-invasive therapy conversation treatment.

[17] Becerra-Culqui TA, Liu Y, Nash R, et al. (2018). Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. *Pediatrics, 141(5):* e20173845 ; https://pubmed.ncbi.nlm.nih.gov/30476120-letter-to-the-editor-endocrine-treatment-of-gender-dysphoricgender-incongruent-persons-an-endocrine-society-clinical-practice-guideline/

[18] Finland: PSYCHIATRIC DISORDERS

Adolescent applicants for “sex reassignment” services

at one of Finland’s two national centers for these services from 2011 to 2013

- 75% had psychiatric treatment for reasons other than gender dysphoria during their lifetime. (p. 5)
- “Severe psychopathology preceding onset of gender dysphoria was common.”
- “The recorded comorbid disorders were thus severe and could seldom be considered secondary to gender dysphoria.”

(Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health, abstract, p. 6. https://doi.org/10.1186/s13034-015-0042-y)

[19] FINLAND: BULLYING with Mental Disorders Came *Before* Gender Incongruence for Adolescents Applying for “Sex Reassignment” Services (2015):

- 57% had been significantly bullied at school.
    - 92% of these were bullied before gender incongruence.
    - 73% were bullied for reasons unrelated to gender presentation or gender identity.
- 49 % had been *persistently* bullied *before* gender incongruence.
    - This bullying was associated with *peer isolation, anxiety, depression, self-harm, and suicidal preoccupation, if not attempts*.
    - These adolescents had “very high expectations” that gender medical procedures “would solve their problems in social, academic, occupational and mental health domains.” (pp. 4-6).

(Kaltiala-Heino et al., 2015, p. 4, “e group” on Table 2 and on p. 6). https://doi.org/10.1186/s13034-015-0042-y)

[20] Finland’s treatment “Recommendation” says, “The first-line treatment for gender dysphoria” includes treatment “of possible comorbid disorders” that may “predispose a young person to the onset of gender dysphoria.” (COHERE, 2020, chapter 7) This is exactly what therapists in the IFTCC do and trained pastoral counsellors support and what “conversion therapy” bans would criminalize.

FINLAND: Council for Choices in Health Care in Finland (PALKO/COHERE Finland) (2020). Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. Unofficial English translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

[21] **World Professional Association for Transgender Health** (WPATH)
“Gender dysphoria" may be “secondary to or better accounted for by other diagnoses.”

WPATH(2011). Standards of Care, http://www.wpath.org/ site_page.cfm?pk_association_webpage_menu=1351, p. 24

[22] **American Psychiatric Association**
Regarding adolescents: “Both of these teams concur that management of those in whom GID [gender identity disorder] has persisted from childhood is more straightforward than management of those in whom GID is of more recent onset. In particular, the latter group is more likely to manifest significant psychopathology in addition to GID. This group should be screened carefully to detect the emergence of the desire for sex reassignment in the context of trauma as well as for any disorder such as schizophrenia, mania or psychotic depression that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent’s decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition.” (p. 764)

Byne, W., Bradley, S.J., Coleman, E., Eyler, A.E., Green, R., Menvielle, E.J., Meyer-Bahlburg, H.F.L., Pleak, R.R., & Tompkins, D.A. (2012). Report of the American Psychiatric Association Task Force on treatment of gender identity disorder. *Archives of Sexual Behavior, 41*, 759-796. https://link.springer.com/article/10.1007%2Fs10508-012-9975-x

[23] **The British Psychological Society** Guideline says, “In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger’s syndrome….” (p. 26)

British Psychological Society (BPS) (2012). Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. https://www.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20-for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20-Gender%20Minority%20Clients%20(2012).pdf

[24] Researchers found that, worldwide, 90% of people who completed suicide had mental disorders. Their number one recommendation for preventing suicide was to treat mental disorders.

“Suicide prevention strategies may be most effective if focused on the treatment of mental disorders." (abstract)
“…it is our opinion that the core responsibility of doctors in trying to reduce suicide rates remains the identification and treatment of mental disorders.” (p. 402)

Cavanagh, J.T.O., Carson, AJ., Sharpe, M. & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine, 33*:395–405. Cambridge University Press DOI: 10.1017/S003329170200694 ; https://www.cambridge.org/core/journals/psychological-medicine/article/psychological-autopsy-studies-of-suicide-a-systematic-review/49EEDF1D29B26C270A2788275995FDEE

[25] Sexual orientation changes over the life span. (Repeat of a previous footnote.)

American Psychological Association’s *APA Handbook of Sexuality and Psychology* (2014):

- “[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.”

(Diamond, 2014, in *APA Handbook*, v. 1, p. 636)

- “Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation.”

(Rosario & Schrimshaw, 2014, *APA Handbook*, v. 1, p. 562)

- “Over the course of life, individuals experience the following:…changes or fluctuations in sexual attractions, behaviors, and romantic partnerships.”

(Mustanski, Kuper, & Greene, 2014, in *APA Handbook*, v. 1, p. 619.)

Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association.

[26] Two-thirds of minors questioning their sexual orientation resolve to heterosexual.

“In addition, we found that, of those who described themselves as “unsure” of their orientation identity at any point, 66% identified as completely heterosexual at other reports and never went on to describe themselves as a sexual minority.” (Abstract)

Ott, M. Corliss, H., Wypij, D., Rosario, M., Austin, B. (2011) Stability and change in self-reported sexual orientation in young people: Application of mobility metrics. Archives of Sexual Behavior, 40: 519–532. doi:10.1007/s10508-010-9691-3; Author manuscript available in PMC 2012, June 1.

[27] Of all men who experienced same-sex behavior, 42% did so before age 18 and never again. Laumann, E.O., Gagnon, J.H., Michael, R.T., and Michaels, S. (1994). *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago and London: The University of Chicago Press.

[28] CHILDREN USUALLY OUTGROW GENDER DYSPHORIA after puberty—by late adolescence or adulthood—if allowed to. About 85% resolve.

ORGANIZATIONS
saying gender dysphoria usually resolves by adolescence or adulthood:

61-98%—American Psychiatric Association, desistance rates calculated from persistence rates.
American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Association, pp. 455.

No less than 75%—American Psychological Association, no more than 25% persist:
Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). APA Handbook of Sexuality and Psychology. Volume 1. Person Based Approaches. Pp. 739-758. Washington D.C.: American Psychological Association. https://www.apa.org/pubs/books/4311512

85%—Endocrine Society plus 6 co-sponsoring organizations including the World Professional Association for Transgender Health (WPATH):
Hembree, W. et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism, 102,* 10. https://doi.org/10.1210/jc.2017-01658

RESEARCH:

88%—Singh D., Bradley S.J., and Zucker K.J. (2021) A Follow-Up Study of Boys With Gender Identity Disorder. Frontiers in Psychiatry, 12, 632784. https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full
61098%—Ristori, J. & Steensma, T.D. (2016). Gender dysphoria in childhood. International Review of Psychiatry, 28(1), 13-20. http://dx.doi.org/10.3109/09540261.2015.1115754
80-95%—Cohen-Kettenis P., Delemarre-van de Waal, H., & Gooren, L. (2008). The treatment of adolescent transsexuals: Changing insights. *Journal of Sexual Medicine, 5*, 1892–1897. https://doi.org/10.1111/j.1743-6109.2008.00870.x

REBUTTAL:
An effort to erase the research behind this reality has been well critiqued.

Zucker, K. (2018). The myth of persistence: Response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender non-conforming children” by Temple Newhook et al. (2018). *International Journal of Transgenderism.* https://www.tandfonline.com/doi/abs/10.1080/15532739.2018.1468293

[29] GENDER IDENTITY CHANGES THROUGHOUT THE LIFE SPAN.

British Psychological Society Guidelines:

“Gender dysphoria can fluctuate over years, not infrequently increasing or decreasing in mid life and it is not unusual for people to present for therapeutic discussion and support later in life”.

British Psychological Society (BPS) (February 2012). Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients, p. 25. https://www.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20(2012).pdf

[30] DRESSING AND LIVING AS ANOTHER SEX AND BEING GIVEN PUBERTY BLOCKERS MAY STOP CHILDREN’S NATURAL RESOLUTION OF GENDER DYSPHORIA.

American Psychological Association:

“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….the stress associated with possible reversal of this decision has been shown to be substantial (Steensma et al., 2011).” (*1*:744)

Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). APA Handbook of Sexuality and Psychology. Volume 1. Person Based Approaches. Pp. 739-758. Washington D.C.: American Psychological Association. https://www.apa.org/pubs/books/4311512

Endocrine Society plus 6 co-sponsoring organizations
including the World Professional Association for Transgender Health (WPATH):

“However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/ gender incongruent in adolescence. If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty. Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence….However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.” (p. 11)

Hembree, W., Cohen-Kettenis, P., Gooren, L., Hannema, S., Meyer, W., Murad, M., Rosenthal, S., Safer, J., Tangpricha, V., & T’Sjoen, G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology and Metabolism, 102, 1–35. https://doi.org/10.1210/jc.2017-01658

[31] PUBERTY BLOCKERS STOP NATURAL RESOLUTION OF GENDER DYSPHORIA ACCORDING TO RESEARCH.

Once children are given puberty blockers that prevent them from experiencing hormones natural to their sex, virtually all go on to be given cross sex hormones and be sterilized for life. If left alone, 75% to 98% of children resolve their gender dysphoria spontaneously through life experience or through experiencing the hormones natural to their sex. Puberty blockers are not a “pause button” but rather the “entry drug” that locks them in to going on to cross sex hormones.

2% stopped puberty blockers. 98% went on to cross sex hormones and being sterilized. There was no psychological improvement with puberty blockers, even with psychological support.

Carmichael, P., Butler, G., Masic, U., Cole, T.J., De Stavola, B.L., Davidson, S., et al. (2021) Short- term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS ONE 16(2): e0243894. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0243894

None stopped puberty blockers. 100% went on to be cross sex hormones and being sterilized.

de Vries, A.L.C., Steensma, T.D., Doreleijers, T.A.H., & Cohen-Kettenis, T.C. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. Journal of Sexual Medicine, 8(8), 2276-83. https://pubmed.ncbi.nlm.nih.gov/20646177/

6% stopped puberty blockers, some due to adverse side effects, and 3.5% because they no longer wanted to change their bodies. 94% went on to cross sex hormones and being sterilized.

Brik, T., Vrouenraets, L.J.J.J., deVries, M.C., Hannema, S.E. (2020). Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. Archives of Sexual Behavior, 49, 2611-2618. https://doi.org/10.1007/s10508-020-01660-8

[32] **Children’s Hospital Los Angeles** consent form for gender affirming hormones:
Puberty blockers plus cross-sex hormones sterilize children. “If your child starts puberty blockers in the earliest stages of puberty, and then goes on to gender affirming hormones, they will not develop sperm or eggs. **This means that they will not be able to have biological children**.” (p. 32)
Estrogen for boys/men may affect fertility and sexual function permanently.
“Sperm may not mature, leading to reduced fertility. The ability to make sperm normally may or may not come back even after stopping taking feminizing medication….”
“Testicles may shrink by 25-50%….”
“Erections may not be firm enough for penetrative sex.” (p. 28).
Testosterone for girls/women may affect fertility permanently.
“It is not known what the effects of testosterone are on fertility. Even if you stop taking testosterone it is uncertain if you will be able to get pregnant in the future.” (p. 35)
Children’s Hospital Los Angeles (2016). Children’s Hospital Los Angeles Assent to Participate in Research Study. https://drive.google.com/file/d/1Q-zJCivH-QW7hL25idXT_j-ITfJZUUm1w/view?usp=sharing
See also:
Olson-Kennedy, J., Rosenthal, S.M., Hastings, J. & Wesp, L. (2016). Health considerations for gender nonconforming children and transgender adolescents: Gender Affirming Hormones: Preparing for gender-affirming hormone use in transgender youth. University of California at San Francisco (UCSF) Medical Center, Transgender Care. https://transcare.ucsf.edu/guidelines/youth
Fenway Health (2019). Informed Consent Form for Puberty Suppression. https://fenwayhealth.org/wp-content/uploads/Informed-Consent-for-Puberty-Suppression-4-2019.pdf

[33] Dhejne C, Lichtenstein P, Boman M, Johansson ALV, La˚ngstro¨m N, et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. PLoS ONE 6(2): e16885. doi:10.1371/journal.pone.0016885.

[34] An Obama administration US gov. research review said Dhejne et al. (2011) is one of the best studies we have.
Centers for Medicare & Medicaid Services (August 30, 2016). Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), p. 62, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282 .

[35] An international research review in 2016 claimed these body harming procedures improve psychiatric disorders. “In summary, this review indicates that, although the levels of psychopathology and psychiatric disorders of trans people attending transgender health-care services are higher than the cis [sex accepting] population at the time of assessment, they do improve following gender-confirming medical intervention, in many cases reaching normative values.” (Dhejne et al., 2016) The studies reviewed were not sufficient to warrant the conclusion of mental health improvement, because nearly all the studies were too short to find end point outcomes, only following participants for 3 months to 5 years. The 30-year study by Dhejne et al. (2011, reported above) had found suicide rates increased after 10 years. The studies reviewed in this 2016 report that were longer than 5 years included one 9 year study that had only 22 participants and lost 30% of them to follow-up, leaving a vanishingly small number of participants. The other exception was a 13.3 year study that lost half its participants to follow-up, making it impossible to draw any generalizations about outcomes.

This review does acknowledge, "Overall, it was found that trans people attending transgender health-care services present with a high prevalence of psychiatric disorders and psychopathology.” (p. 52)

Dhejne, C., Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature.. *International Review of Psychiatry, 28(1)*, 44-57. https://doi.org/10.3109/09540261.2015.1115753

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A., La˚ngstro¨m, N., Landén, M. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE 6(2)*, e16885. https://pubmed.ncbi.nlm.nih.gov/21364939/

[36] A small 2018 study near San Francisco, purporting to show harm to minors from “conversion therapy,” looked at only parent-initiated efforts. Ethical change-exploring therapists do not do parent-initiated therapy, so this research does not apply to them. By research design, the study excluded any youth who may have changed through therapy, since researchers recruited research participants only from LGBT-supportive venues, and youth who changed do not go to these venues. This method is common in research that claims to show harm. As Dr. Christopher Rosik says, it is like surveying divorcees to find out if marital therapy is safe or effective. The survey said it did not study client-initiated therapy at all. It has nothing to say about it.

Ryan, C., Toomey, R., Diaz, R., & Russell, S. (2018). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment, *Journal of Homosexuality*,DOI:10.1080/00918369.2018.1538407, published online Nov. 7, 2018.

[37] Several countries with the longest experience of medical gender services are increasingly restricting these interventions for minors:

FINLAND: Council for Choices in Health Care in Finland (PALKO/COHERE Finland) (2020). Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. Unofficial English translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

SWEDEN: Karolinska Universitetssjukhuset Astrid Lindgrens Barnsjukhus (March 2021). Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria at Tema Barn-Astrid Lindgren Children’s Hospital. Swedish: https://segm.org/sites/default/files/Karolinska_Policy_Statement_Swedish.pdf ; Unofficial English translation: https://segm.org/sites/default/files/Karolinska%20_Policy_Statement_English.pdf

THE NETHERLANDS: De Vries, A.L.C., Steensma, T.D., Doreleijers, T.A.H., & Cohen-Kettenis, P.T. (2011). Puberty sup[pression in adolesceents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine, 8*, 2276–2283. https://www.sciencedirect.com/science/article/abs/pii/S1743609515336171

UK: A United Kingdom High Court in Bell vs. Tavistock (Dec. 12, 2020) ruled that medical gender affirming treatment in minors was experimental and could not, in most cases, be given to minors under 16 without court order, and that such was advisable for those 16-17. They added, “There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.” (Bell et al. v. GIDS, UK, 2020, https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf). This case is going through appeals.

UK: Transgender Trend (2019). The surge in referral rates of girls to the Tavistock continues to rise. https://www.transgendertrend.com/surge-referral-rates-girls-tavistock-continues-rise/ (p. 3

[38] Finland’s “Recommendation” calls for treating gender dysphoric minors by treating predisposing psychiatric disorders and not resorting to medical interventions.

- Finland’s treatment “Recommendation” said medical gender affirming treatments are not treatments for psychiatric disorders. “Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment.” (COHERE, 2020, chapter 6)

- It further said children and adolescents should postpone any body altering interventions until their other disorders are treated first, so it is possible to diagnose whether they still have gender dysphoria, and until their brains mature, preferably to age 25, and they are able to access the consequences of lifelong infertility and health risks. (chapter 6)

- ***In fact, Finland’s treatment “Recommendation” says, “The first-line treatment for gender dysphoria” includes treatment “of possible comorbid disorders” that may “predispose a young person to the onset of gender dysphoria.”*** (COHERE, 2020, chapter 7) ***This is exactly what professional change-exploring therapists do and trained pastoral counsellors support and what “conversion therapy” bans would criminalize.***

FINLAND: Council for Choices in Health Care in Finland (PALKO/COHERE Finland) (2020). Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. Unofficial English translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

[39] The largest study in The Netherlands found the transgender suicide risk was higher than for the general population over 45 years (1972 to 2017).

- “…the suicide risk in transgender people is higher than in the general population and seems to occur during every stage of transitioning.” (abstract)

- “Although the incidence of suicide deaths in trans women decreased over the years, the overall incidence still showed to be higher in trans women compared with trans men.” (p. 5)

- “This study is performed in the largest cohort of gender-referred people from the Netherlands, consisting of a large population of both adult and adolescent trans women and trans men at different stages of their transition with a long follow-up time.” (p. 5)

- A limitation of the study was, “we did not have information about psychological comorbidities….” (p. 5)

Wiepjes, C.M., den Heijer, M., Bremmer, M.A., Nota, N.M., de Blok, C.J.M., Coumou, B.J.G. & Steensma, T.D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). Acta Psychiatrica Scandinavica, 1-3. https://pubmed.ncbi.nlm.nih.gov/32072611/

[40] Children who are given gender affirming puberty blockers or cross sex hormones have greater mental health problems than sex accepting peers, even when they have parent support for gender transition, contrary to claims of two frequently cited studies.

“Together, both articles have been cited over 370 times in the past two or three years. Chen et al. (2018, 76) found the two studies to be the only ones that had yet “explored psychosocial functioning in socially transitioned prepubertal children,” high-lighting the critical importance of the two studies. As noted, Kuvalanka, Gardner, and Munroe (2019, 103) cited the research as “pioneering.” It is clear that the reported results of these two studies have had a huge impact on the field of social science and medicine.” (p. 19)

“Outright errors were made. The issues we have brought up were significant enough to have caught the attention of peer reviewers and been corrected prior to publication; for that matter, the journal editors might have caught at least some of them on their own, prior to peer review.” (p. 21)

“Whereas Olson et al. (2016b) and Durwood, McLaughlin, and Olson (2017) concluded that trans-gender children with strong parental support had, at worst, only slightly higher levels of anxiety with no differences in self-worth or depression; a reanalysis of their findings suggests otherwise, with slightly higher levels of depression but significantly and substantively meaning- ful differences in anxiety and self-worth, and with results favoring cisgender children, even when the transgender children had high levels of parental support for their gender transition- ing.“ (p. 21)

Schumm, W. R. & Crawford, D. W. (2019). Is research on transgender children what it seems? Comments on recent research on transgender children with high levels of parental support. *The Linacre Quarterly, 87(1),* 9-24. https://journals.sagepub.com/doi/10.1177/0024363919884799

[41] The researchers were the originator of the minority stress theory and colleagues. They reported this study was the “first large scale”, nationally representative study and the first to ask questions and use measures specific to the LGBT-identified population. The researchers concluded their findings concur with findings of other researchers, that “disparities by sexual identity have not been declining, but instead increasing.”

Meyer, I.H., Russell, S.T., Hammack. P.L., Frost, D.M., Wilson & Bianca, D.M. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A U.S. probability sample, PLoS ONE, 16(3), 1-19. https://pubmed.ncbi.nlm.nih.gov/33657122/

[42] USA nationally representative study using Pew Research data:
“Surprisingly, no significant differences are found between mainline Protestants (whose church doctrine often accepts same-sex relations) and evangelical Protestants (whose church doctrine often condemns same-sex relations).” (Abstract)
“LGBT respondents report a general feeling of happiness (.85) [85%] that is similar to that of the general population (.86) [86%] reported by the General Social Survey." (p. 85)
Barringer, M. & Gay, D. (2017). Happily religious: The surprising sources of happiness among lesbian, gay, bisexual, and transgender adults. Sociological Inquiry, 87, 75-96. https://doi.org/10.1111/soin.12154

[43] Cranney, S. (2017). The LGB Mormon paradox: Mental, physical, and self-rated health among Mormon and non-Mormon LGB Iindividuals in the Utah Behavioral Risk Factor Surveillance System, *Journal of Homosexuality, 64:(6)*, 731-744. https://doi.org/10.1080/00918369.2016.1236570

[44] Rosik, C.H., Lefevor, G.T., & Beckstead, A.L. (2021). Sexual minorities who reject an LGB identity: Who are they and why does it matter? *Issues in Law and Medicine*, *36*(1), 7-43. https://www.researchgate.net/publication/351331363_Sexual_Minorities_who_Reject_an_LGB_Identity_Who_Are_They_and_Why_Does_It_Matter
Lefevor, G., Beckstead, L., Schow, R., Raynes, M., Mansfield, T., Rosik, C. (2019). Satisfaction and health within four sexual identity relationship options. *Journal of Sex and Marital Therapy*. https://doi.org/10.1080/0092623X.2018.1531333

[45] According to the American Psychological Association and abundant rigorous research internationally, MOST PEOPLE WHO EXPERIENCE SAME-SEX ATTRACTION ALSO EXPERIENCE EQUAL OR GREATER OPPOSITE-SEX ATTRACTION. THEY COMMONLY SHIFT ALONG A SCALE that ranges from exclusively homosexual to mostly homosexual to bisexual (about equally attracted to both sexes) to mostly heterosexual to exclusively heterosexual. They change mostly toward or to exclusively heterosexual. Researchers who are themselves LGB consider a change of 1 or 2 steps along that spectrum to be sexual orientation change. **Even a change of 1 or 2 steps along that spectrum toward less opposite sex attraction or greater opposite-sex attraction may enable someone to live their dream. Shouldn’t they have the right to counseling they may need and desire to explore their capacity to make that change? Contemporary change-exploring therapists do not guarantee categorical change from exclusively homosexual attraction to exclusively heterosexual attraction. A partial change can change a life.**

“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.

Diamond (2014), in *APA Handbook of Sexuality and Psychology, 1*:633; see also Diamond, L. & Rosky, C. (2016), Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research, 00*:1-29. DOI: 10.1080/00224499.2016.1139665.

“The largest identity group, second only to heterosexual, was 'mostly heterosexual’ for each sex and across both age groups, and that group was 'larger than all the other non-heterosexual identities combined’” (abstract). “The bisexual category was the most unstable” with three quarters changing that status *in 6 years* (abstract). “[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality” (p 106).

Savin-Williams, R., Joyner, K., & Rieger, R. (2012). Prevalence and stability of self-reported sexual orientation identity during young adulthood. *Archives of Sexual Behavior 41:* abstract, p. 106. https://link.springer.com/article/10.1007/s10508-012-9913-y; reviewed in Diamond & Rosky (2016), p. 7, Table 1; Diamond (2014), in *APA Handbook, 1*:638.

Mostly heterosexual individuals generally do not identify as LGB and can get overlooked by research or popular surveys.

[46] Many same sex attracted individuals are in opposite sex relationships.

In the US, a nationally representative study found that, of bisexual men and women who were in any relationship, the vast majority were in an opposite sex relationship (88% of bisexual men and 90% of bisexual women), most of them married. (Herek et al., 2010, Table 8; p. 194.)

In the U.K. in 2017, approximately 17% of LGB identified individuals were married, 12% to the opposite sex and 5% to the same sex. Therefore, more than two/thirds of married LGB identified people, or 71%, were married to the opposite sex. (ONS, 2017)

Lifetime, 31% of LGB identified people had ever been married or in a civil union (reported as 69% had never been). (ONS, 2017)

Herek, G.M., Norton, A.T., Allen, T.J., & Sims, C.L. (2010). Demographic, psychological, and social characteristics of self-identified lesbian, gay, and bisexual adults in a US probability sample. *Sexuality Research Social Policy, 7*, 176–200. https://link.springer.-com/content/pdf/10.1007%2Fs13178-010-0017-y.pdf
Office of National Statistics (ONS) (2017). Sexual orientation, UK:2017; Experimental statistics on sexual orientation in the UK in 2017 by region, sex, age, marital status, ethnicity and socio-economic classification. *Statistical Bulletin*, p. 9, Figure 5. Sexual orientation, UK 2017.pdf ;
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017

[47] In marriages where one spouse experiences same-sex attraction, couples may experience satisfaction in their relationship that is real.
(Lefevor, et al, 2019; Yarhouse et al., 2003; and Pomeroy, 1972 reporting on Kinsey.)

If a same sex attracted person is in a satisfying opposite sex relationship, opposite sex attraction may increase and same sex attraction may decrease. Therapists help people experience fulfilling relationships and therefore may help people experience an increase in opposite sex attraction and decrease in same sex attraction.
(Diamond, 2008; Yarhouse, 2003; Pomeroy, 1972, re Kinsey)

Lefevor, G., Beckstead, L., Schow, R., Raynes, M., Mansfield, T., Rosik, C. (2019). Satisfaction and health within four sexual identity relationship options. Journal of Sex and Marital Therapy. https://doi.org/10.1080/0092623X.2018.1531333
Yarhouse M., Pawlowski L., Tan E. (2003). Intact marriages in which one partner dis-identifies with experiences of same-sex attraction.
American Journal of Family Therapy, 31(5), 375–394.
https://www.tandfonline.com/doi/abs/10.1080/01926180390223996
Pomeroy, W. B. (1972), Dr. Kinsey and the Institute for Sex Research, N.Y: Harper and Row, Pub., pp. 75-77.
Diamond, L. (2008). *Sexual Fluidity: Understanding Women’s Love and Desire*. Cambridge, Mass.: Harvard Press. http://www.hup.harvard.edu/catalog.php? isbn=9780674032262

[48] **Therapy bans criminalize gay-affirmative therapists and discriminate against LGB marriages if they prohibit support to decrease unwanted same sex behaviors.**

Gay affirmative researchers have published in peer-reviewed journals several articles of replicated, randomized, controlled trials showing men who have sex with men significantly reduced casual same sex behavior they did not want through standard therapies conducted by gay affirmative therapists and through gay peer counselors and maintained the change at 6 month, 8 month, and 1 year follow up evaluations. Over these studies taken together, men from a wide range of levels of education and income were successful. In the largest and most recent of these studies (Nyamathi et al., 2017), men who had children and men for whom same sex behavior was inconsistent with their values (high “homonegativity”) were particularly successful in reducing unwanted casual same sex behavior. The researchers’ purpose for these interventions was to reduce drug use and risky same sex behavior in order to decrease risk of HIV transmission. (Nyamathi 2017; Roeback 2014; Shoptaw 2008; 2005) Perhaps these particularly successful men wanted help to be faithful to the wife they love more easily, in order to keep their marriage and family together, or wanted to live according to the religious faith of their heart—two of the most common reasons people seek change-exploring therapy. Under a therapy ban, gay-affirmative therapists would be punished for providing potentially life saving therapy, and there would be marriages and families of sexual minorities that cannot be saved.

A separate study of 125 men who experienced therapy that is open to exploring capacity to change same sex attraction and behavior found that 41% were married, most of them with children—3 children each on average. Also, 88% of participants attended religious services at least once per week. For the men in this convenience sample, same sex behavior plummeted from 71% before therapy to 14% after therapy, and 69% decreased same sex attraction. Sexual behavior, ideation, desire for intimacy, and kissing changed significantly from homosexual and to heterosexual. What this means to these men, their wives, and their children can hardly be expressed in words. In addition, 61% increased self esteem, 73% decreased depression, and 22% decreased suicidality. (Sullins 2021)

Nyamathi, A., Reback, D.J, Shoptaw, S., Salem, B.E., Zhang, S. & Yadav, K. (2017). Impact of tailored interventions to reduce drug use and sexual risk behaviors among homeless gay and bisexual men. *American Journal of Men’s Health, 11(2)*, 208–220. https://journals.sagepub.com/doi/abs/10.1177/1557988315590837

Reback, C. J., & Shoptaw, S. (2014). Development of an evidence-based, gay-specific cognitive behavioral therapy intervention for methamphetamine-abusing gay and bisexual men. *Addictive Behaviors, 39*, 1286-1291. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3326187/pdf/nihms340906.pdf

Shoptaw, S., Reback, C.J., Larkins, S., Wang, P., Rotheram-Fuller, E., Dang, J., & Yang, X. (2008). Outcomes using two tailored behavioral treatments for substance abuse in urban gay and bisexual men. *Journal of Substance Abuse Treatment, 35*, 285-293. https://asu.pure.elsevier.com/en/publications/outcomes-using-two-tailored-behavioral-treatments-for-substance-a

Shoptaw, S., Reback, C.J., Peck, J.A., Yan, X., Rotheram-Fuller, E., Larkins, Sh., Veniegas, R.C., Freese, T.E., & Hucks-Ortiz, C. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men. *Drug and Alcohol Dependence, 78*, 125-134. See Table 1 and p. 132. https://ucdavis.pure.elsevier.com/en/publications/behavioral-treatment-approaches-for-methamphetamine-dependence-an

Sullins, D.P., Rosik, C.H., and Santero, P. (April 27, 2021). Efficacy and risk of sexual orientation change efforts: a retrospective analysis of 125 exposed men. *F1000Research, 10:222*, 1-20. https://doi.org/10.12688/f1000research.51209.1

[49] Pela, C. & Sutton, P. (2021). Sexual attraction fluidity and well-being in men: A therapeutic outcome study. Journal of Human Sexuality, 12, 61-86. https://df6a7995-c8cd-4a49-bc0d-2ef92e2cf904.filesusr.com/ugd/ec16e9_08ac87b9a4a94711b6b72429723cda6a.pdf

[50] Sullins, D., Rosik, C., and Santero, P. (April 27, 2021). Efficacy and risk of sexual orientation change efforts: a retrospective analysis of 125 exposed men. https://f1000research.com/articles/10-222/v2

[51] Jones, S.L. & Yarhouse, M.A. (2011). A longitudinal study of attempted religiously mediated sexual orientation change. Journal of Sex & Marital Therapy, 37, 404–427. https://doi.org/10.1080/0092623X.2011.607052

[52] “For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation, gender identity, sexual behavior, sexual orientation identity….” APA Task Force (2009), p. 49.

[53] **On research through 2009:**
Report Summary: What research shows: NARTH’s response to the APA claims on homosexuality: Summary of *Journal of Human Sexuality* (Volume I), pp. 1-5. https://www.scribd.com/document/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1.
Full Report: Phelan, J., Whitehead, N., & Sutton, P.M. (2009). 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. *Journal of Human Sexuality, 1:* 1-121. https://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1
On research 2000 to present:
Sprigg, P. (2018). Are Sexual Orientation Change Efforts (SOCE) Effective? Are They Harmful? What the Evidence Shows, Family Research Council, https://www.frc.org/issueanalysis/are-sexual-orientation-change-efforts-soce-effective-are-they-harmful-what-the-evidence-shows :
Read the Full Version (Issue Analysis): https://downloads.frc.org/EF/EF18I04.pdf
Read the Abbreviated Version (Issue Brief Report Summary): https://downloads.frc.org/EF/EF18I05.pdf

[54] A federal district judge ended a city therapy ban pertaining to minors in Tampa, Florida, because even the highly qualified expert witnesses for the city admitted there is no evidence that meets scientific standards that shows therapy that is open to a minor client's goal of change is unsafe or ineffective. http://lc.org/PDFs/Attachments2PRsLAs/100419TampaOrderGrantingMSJ.pdf, p. 32.

[55] Excerpt from the 11th Circuit Court decision:

> Defendants say that the ordinances “safeguard the physical and psychological well-being of minors.” Together with their amici, they present a series of reports and studies setting out harms. But when examined closely, these documents **offer assertions rather than evidence**, at least regarding the effects of purely speech-based SOCE. Indeed, a report from the American Psychological Association, relied on by the defendants, concedes that “nonaversive and recent approaches to SOCE have not been rigorously evaluated.” In fact, it found a “complete lack” of “rigorous recent prospective research” on SOCE. As for speech-based SOCE, the report notes that recent research indicates that those who have participated have mixed views: “there are individuals who perceive they have been harmed and others who perceive they have been benefited from nonaversive SOCE.” What’s more, because of this “complete lack” of rigorous recent research, the report concludes that it has “no clear indication of the prevalence of harmful outcomes among people who have undergone” SOCE. We fail to see how, even completely crediting the **report**, such **equivocal conclusions** can satisfy strict scrutiny and overcome the strong presumption against content-based limitations on speech.
>
> Still, they say, our confidence should not be shaken: the “relative lack of empirical studies on SOCE is not evidence of lack of harm….If anything, the lack of studies on SOCE may be indicative of the risk of harm.” The district court agreed: “Requiring Defendants to produce specific evidence that engaging in SOCE through talk therapy is as harmful as aversive techniques would likely be futile when so many professional organizations have declared their opposition to SOCE.” In other words, evidence is not necessary when the relevant professional organizations are united.
>
> But that is, really, just another way of arguing that majority preference can justify a speech restriction. The “point of the First Amendment,” however, “is that majority preferences must be expressed in some fashion other than silencing speech on the basis of its content.” Strict scrutiny cannot be satisfied by professional societies’ opposition to speech. Although we have no reason to doubt that these groups are composed of educated men and women acting in good faith, their institutional positions cannot define the boundaries of constitutional rights. They may hit the right mark—but they may also miss it.
>
> Sometimes by a wide margin too. It is not uncommon for professional organizations to do an about-face in response to new evidence or new attitudes….

Otto, et al v. City of Boca Raton, FL et al:
Press release: https://lc.org/newsroom/details/112020-court-of-appeals-strikes-down-fl-counseling-ban-1
The legal decision: https://lc.org/PDFs/Attachments2PRsLAs/112020Otto.pdf

[56] Sullins found that change-exploring interventions actually decrease suicidality for people who did not change sexual attraction through mental health professional therapy or care from a religious leader. He studied a nationally representative sample of 1,518 people who identify as LGB, therefore who presumably did not change sexual attraction through such interventions. Therefore, the generalization can legitimately be made that professional and religious counseling reduces suicidality for minors and adults and dramatically reduces suicidality—by 17 to 25 times—for adults who identify as LGB and therefore presumably did not change sexual attraction or identity through these efforts. Expressed another way, a generalization claiming harm for people who do not change is not supported and is invalid.

Sullins, D. (2021). Sexual orientation change efforts (SOCE) reduce suicide: Correcting a false research narrative.
http://dx.doi.org/10.2139/ssrn.3729353

[57] Recipe for Deceptive Harm Claiming Research

- Do not define “conversion therapy” or mischaracterize what we do.

- Use only LGBT-identified participants—people who by definition did not change. People who changed are not permitted to participate.
  Psychologist/Researcher Dr. Christopher Rosik:
  Like surveying divorcees to find out if marriage counseling is safe or effective.

- Biased Qs: Example: Did someone try to *make you* change? Assumes coercion.

- Mix professional therapy with pastoral caregiving, parent “conversion therapy,” or more. “Conversion therapy” could mean someone asked their pastor to pray with them once, a parent encouraged a child to wait until age 18 to become sexually active or to decide about permanently changing their body, or a physician told them the benefits and also the harms of gender medical interventions. We do not know what was studied.

- Ask participants only if they are depressed or suicidal now (after therapy), and not if they were before therapy. Then assume therapy caused how they are presently.
  These symptoms could have been higher before therapy and decreased after therapy.
  Like saying people who have had anti-depressants are more depressed and suicidal than people who have not sought or had anti-depressants. Therefore anti-depressants cause depression and suicidal thoughts and should be banned. Banning the cure.

- Do not compare “conversion therapy” to "any therapy in general” or “affirmative therapy”.
  It is likely, if not probable, that people who go to any therapy—including affirmative therapy or change-exploring therapy—have more suicidality than people who do not go to therapy.

Example: Blosnich et al (2020) made all these mistakes except they did define “sexual orientation change efforts”.

Blosnich, J., Henderson, E, Coulter, R, Boldbach, J., & Meyer, I. (2020). Sexual orientation change efforts, adverse childhood experiences, and suicide ideation and attempt among sexual minority adults, United States, 2016-2018. *American Journal of Public Health Surveillance, 110(7),* 1024-1030. https://pubmed.ncbi.nlm.nih.gov/32437277/)

[58] Examples of harm studies that use some or all of these biased methods (p. 1)

Dehlin, J.P., Galliher, R.V., Bradshaw, W.S., Hyde, D.C., & Crowell, K.A. (2014). Psychosocial correlates of religious approaches to same-sex attraction: A Mormon perspective. *Journal of Gay & Lesbian Mental Health, 18*, 284–311. doi:10.1080/19359705.2014.912970

Dehlin, J.P., Galliher, R.V., Bradshaw, W.S., Hyde, D.C., & Crowell, K.A. (2015), Sexual orientation change efforts among current or former LDS Church members, *Journal of Counseling Psychology, 62,* 95-105, http://dx.doi.org/10.1037/cou0000011

Flentje, A., Heck, N., & Cochran, B.N. (2014). Reorientation therapy: Reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality, 61*:1242–1268. DOI: 10.1080/00918369.2014.926763

Government Equalities Office (July 2018). National LGBT Survey: Research Report. LGBT-survey-research-report.pdfGovernment Equalities Office (July 2018). National LGBT Survey: Research Report. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf

Green, A.E., Price-Feeney, M., Dorison, S.H., Pick, C.J. (2020). Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018. American Journal of Public Health, Open-Themes Research, 110(8), 1221-1227. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.305701

Higbee, M., Wright, E., & Roemerman, R. (2020). Conversion therapy in the southern United States: Prevalence and Experiences of the survivors. Journal of Homosexuality, online. https://doi.org/10.1080/00918369.2020.1840213

Mallory, C., Brown, T. N. T., & Conron, K. J. (2018, January). *Conversion therapy and LGBT youth*. Los Angeles, The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Jan-2018.pdf

Mallory, C., Bown, T., Conron, K. (Jan. 2018), Conversion Therapy and LGBT Youth (Jan. 2018), Williams Institute, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Jan-2018.pdf

[59] Examples of harm studies that use some or all of these biased methods (p. 2)

Meanley, S., Haberlen, S., Okafor, C., Brown, A., Brennan-Ing, M., Ware, D., Egan, J., Teplin, L., Bolan, R., Friedman, M., and Plankey, M. (2020). Lifetime exposure to conversion therapy and psychosocial health among midlife and older adults men who have sex with men. The Gerontologist, 60(7), 1291-1302. https://jhu.pure.elsevier.com/en/publications/lifetime-exposure-to-conversion-therapy-and-psychosocial-health-a

Ozanne Foundation Advisory Board (2018). Faith & Sexuality Survey 2018 Executive Report. https://ozanne.foundation/faith-sexuality-survey-2018/

Ryan, C., Toomey, R.B., Diaz , R.M. & Russell , S.T. (2018). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment, *Journal of Homosexuality*, 67(2), 159-173. https://doi.org/10.1080/00918369.2018.1538407

Salway, T., Ferlatte, O., Gesink, D., and Lachowsky, N. (2020). Prevalence of exposure to sexual orientation change efforts and associated sociodemographic characteristics and psychosocial health outcomes among Canadian sexual minority men.” The Canadian Journal of Psychiatry, 65(7), 502-509. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298582/pdf/10.1177_0706743720902629.pdf

Schroeder, M. & Shidlo, A. (2001). Ethical issues in sexual orientation conversion therapies: An empirical study of consumers. *Journal of Gay & Lesbian Psychotherapy, 5(3/4),* 131-166. Published online 2008: https://www.tandfonline.com/doi/abs/10.1300/J236v05n03_09

Shidlo, A. & Schroeder, M. (2002). Changing sexual orientation: A consumers’ report. Professional Psychology: Research and Practice, 33(3), 249-259. https://pdfs.semanticscholar.org/a8fa/f008ed1c74f105da2ddaf5d20172033e2d4a.pdf

Turban, J.L., Becksith, N., Reisner, S.L. & Keuroghlian, A.S. (2019). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, published online. https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2749479

[60] The Williams Institute (Mallory et al. 2018) estimated that slightly less than 700,000 LGBT-identified adults ages 18 to 59 received “conversion therapy” at some time in their life, about half of them at or before age 18. The Institute did not, however, use data it had available to discover whether “conversion therapy” was harmful for LGB-identified survey respondents. Instead, the Williams Institute led readers to assume “conversion therapy” was harmful. Sullins (2021) did use this available data and found “conversion therapy” decreased suicidaltiy for minors and adults, and dramatically for adults.

The Institute based its estimate on a representative survey of LGB identified adults and a non-representative survey of TGNC identified adults. The surveys asked whether a professional (psychologist or counselor) or religious leader (pastor or priest, advisor, or counselor) tired to “make” them change their sexual orientation or gender identity. The Williams Institute took the figures from these surveys and applied them to various data sets of the US population to arrive at their estimate.

The Generations Study of LGB-identified adults did collect sufficient evidence to answer the question of whether there was a difference in rates of suicidal thoughts, plans, intentions, or attempts before and after “conversion therapy” to help answer the question of whether “conversion therapy” was harmful, but the Institute intentionally did not use it. The researchers just left the reader to assume the interventions were harmful. Blosnich used only the after therapy data and simply assumed the therapy caused those figures. Sullins compared suicidality symptoms from both and after “conversion therapy”, as is necessary to answer the question, and found “conversion therapy” significantly decreased suicidality for minors and adults, especially dramatically for adults—by 17 to 25 times lower.

Since the Generations Study data was solely on adults who currently identify as LGB, it excluded former LGB-identified adults. If former LGB-identified adults had been permitted to participate, the benefit of “conversion therapy” likely would have been greater. Given that the Generations Study is based on a nationally representative survey of LGB-identified adults, that is, adults who did not change sexual attraction through “conversion therapy,” the generalization can legitimately be drawn that LGB-identified minors and adults who do not change through “conversion therapy” do not as a result become more suicidal but rather less suicidal. Therapy has many benefits. “Conversion therapy” for minors and adults is safe and beneficial.

Mallory, C., Bown, T., Conron, K. (Jan. 2018), Conversion Therapy and LGBT Youth (Jan. 2018), Williams Institute, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Jan-2018.pdf

[61] An article by McGeorge et al. (2013) erroneously assumes that knowledge and skills for one subgroup of people who have same sex attraction or behavior applies to all subgroups. This is a common mistake. These authors lack knowledge and skill for treating those who reject an LGB identity. The non-LGB-identified are quite different, and they require quite different treatment and research questions and measures. McGeorge and co-authors shine a light on the great need for ideologically diverse research teams to help researchers see their lack of knowledge and skill regarding **different subgroups** among people who have diverse experiences of sexuality. This work has recently begun, with very helpful findings coming forth.

See following footnote on **“*Non-LGB-identifie*d (versus LGB-identified)”** subgroups among individuals who have diverse experiences of sexuality.

It is likely that clients and therapists who have knowledge and skill for one subgroup regard clients in the other subgroup with skepticism or disbelief in their identity and regard therapists who share the worldview of the other subgroup as not having the right knowledge and skills.

McGeorge, C., Carlson, R., & Toomey. (2013). An exploration of family therapists’ beliefs about the ethics of conversion therapy: The influence of Negative beliefs and clinical competence with lesbian, gay, and bisexual clients. Journal of Marital and Family Therapy. https://doi.org/10.1111/jmft.12040

[62] **Research on change-oriented therapy is being done in silos of subgroups.**

***Non-LGB-identifie*d (versus LGB-identified):**

- **Conservative, orthodox religious beliefs** (p. 22)
  Versus belief in biological origin for same-sex attraction (p. 20)
- **Prioritize religious identity** over sexual feelings (p. 22))
- Greater religious participation/weekly attendance at services (p. 22)
- **Religion and spirituality significantly and positively linked to health (but close to no link for LGBT-identified)** (p. 28)
- Likely get community support from religious community (versus from LGB community)
- **No less healthy than LGB-identified, contrary to the minority stress theory that identifies religion as a source of sexual minority stress** (p. 24)
- Primacy on chastity or heterosexual relationship (p. 22)
- **Report nearly all change-orientated therapy goals as substantially more helpful** (versus harmful) (p. 27)

These findings come from research conducted by an ideologically divers research team of LGBT-affirming and change-affirming researchers.

Rosik, C., Lefevor, G., & Beckstead, L. (2021). Change and acceptance of minority sexual orientation in psychotherapy: Retrospective perceptions of helpfulness and harmfulness. *Journal of Psychology and Christianity*, in press.

[63] Wright, T., et al. (2018). Conversion Therapies and Access to Transition-Related Healthcare in Transgender People. A Narrative Systematic Review. BMJ Open 2018;8:e022425. doi:10.1136/bmjopen-2018-022425

In this research review, the authors identify a gap in research on treatment of gender dysphoria for both medical gender interventions and change-exploring therapy. The authors found only 4 case studies on change-exploring therapy and 3 on medical gender interventions that met certain standards and were published between 1990 and 2017. If accurate, this finding would be a basis for concluding therapy bans that censor change-allowing therapy and support gender medical treatment have had no basis in science. The researchers did arbitrarily dismiss case studies before 1990 of people who decreased or resolved incongruent gender identity through standard psychotherapies (ACPeds, 2021, chart of 15 such studies).

Yet the authors state with certitude, “What is known, however, is that TGD affirmative practices are associated with positive mental health outcomes.” (p. 11) They base this on a single reference to a pilot study of the vanishingly small number of 8 participants with only a 3-month follow-up, during which time depression was decreased and there was no significant difference in coping. The authors demonstrate a breath-taking double standard when they accept this mere pilot study that supports their preferred conclusions as conclusive but considers the other studies to constitute a gap in research. Then, they assert that, in the case of change-exploring therapy, a gap in evidence is to be taken as actual evidence that this therapy is unsafe and ineffective, but regarding the gap in evidence for gender medical interventions, they draw no such conclusion. Asserting that a gap in evidence is evidence violates fundamental principles of the scientific method, and applying their reasoning inconsistently for these different treatment approaches openly declares their bias.

The authors also rely heavily on Newhook and colleagues as having settled the erasing of all the research showing childhood gender dysphoria overwhelmingly resolves through life experience. The same year as this Wright et al., 2018 review was published, Zucker soundly critiqued that attempt at erasure.

The authors Ignored research available to them that actually did meet scientific standards—prospective, longitudinal research of a national cohort—that showed psychiatric problems and suicides persisted at higher rates for decades following hormone and surgery interventions (Sweden: Dhejne et al., 2011). A follow up review by Dhejne et al. (2016) had no studies long enough to give endpoint outcomes nor that retained participants sufficiently to draw conclusions. (More critique in another footnote.) More recent studies at university gender clinics (The Netherlands: Wiepjes, et al., 2020; de Blok et al., 2021) and an entire population study (Sweden: Branstrom & Pachankis, 2020) only underscore that hormones and surgeries do not resolve disorders or suicidality.

The authors reported aversive behavior therapy, that was sometimes used for behavior therapy, the dominant mainstream form of therapy in the 1960s and 1070s, was not effective for resolving gender dysphoria (p. 10). It has largely been abandoned.

The authors appear not to have sufficiently considered research in one of Finland’s two gender clinics (Kaltiala-Heino et al., 2015) and in a cohort in the United States (Becerra-Culqui et al., 2018) showing high rates of psychiatric disorders commonly if not usually precede evidence of onset to gender dysphoria in adolescents, therefore may cause it,

Today, Finland’s “Recommendation” (COHERE, 2020), in line with Finland’s research, says firstline treatment for gender dysphoria should include treating psychiatric disorders that may predispose to gender dysphoria, exactly what contemporary change-exploring therapy does and therapy bans criminalize. This is a disaster.
References at next endnote.

[64] References for Wright et al. 2020 critique on another slide. References listed in order used.

Wright, T., et al. (2018). Conversion Therapies and Access to Transition-Related Healthcare in Transgender People. A Narrative Systematic Review. BMJ Open 2018;8:e022425. https://bmjopen.bmj.com/content/8/12/e022425

American College of Pediatricians (ADPeds) (2021). Psychotherapeutic and behavioral approaches to treating gender dysphoria (including gender identity disorder & transsexualism) in adults and adolescents. https://acpeds.org/assets/Psych-studies-gender-identity-final-17-June-2021.pdf

Zucker, K. (2018). The myth of persistence: Response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender non-conforming children” by Temple Newhook et al. (2018). International Journal of Transgenderism. https://www.tandfonline.com/doi/abs/10.1080/15532739.2018.1468293

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A., La˚ngstro¨m, N., Landén, M. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. PLoS ONE 6(2), e16885. https://pubmed.ncbi.nlm.nih.gov/21364939/

Dhejne, C., Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature.. *International Review of Psychiatry, 28(1)*, 44-57. https://doi.org/10.3109/09540261.2015.1115753

Wiepjes, C.M., den Heijer, M., Bremmer, M.A., Nota, N.M., de Blok, C.J.M., Coumou, B.J.G. & Steensma, T.D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 1-3. https://pubmed.ncbi.nlm.nih.gov/32072611/

Blok, C., Wiepjes, C., van Velzen, D., Staphorsius, A., Nota, N., Gooren, L., Kreukels, B., Heijer, M. (2021). Mortality trends over five decades in adult transgender people receiving hormone treatment: A report from the Amsterdam cohort of gender dysphoria. *The Lancet: Diabetes & Endocrinology,* online. https://www.thelancet.com/journals/landia/article/PIIS2213-8587(21)00185-6/fulltext

Branstrom, R. & Pachankis, J.E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. With correction statement at end. American Journal of Psychiatry 177(8):727-734. https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2019.19010080

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., and Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health, 9, 4-6. https://capmh.biomedcentral.com/articles/10.1186/s13034-015-0042-y

Becerra-Culqui T.A., Liu Y., Nash R., Cromwell, L., Flanders, W.D., Getahun, D., Giammattei, S.V., Hunkeler, E.M., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Sandberg, D.E., Silverberg, M.J., Tangpricha, V., & Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics, 141(5):e20173845. https://pediatrics.aappublications.org/content/141/5/e20173845

Council for Choices in Health Care in Finland (PALKO/COHERE Finland) (2020). Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. Unofficial English translation. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

[65] APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Said aversive methods were abandoned about 40-50 years ago—since about the 1960’s or 1970’s: pp. 22, 82.

[66]APA Task Force (2009).
No causal evidence of harm: pp. 42, 82 91. Reported research participants (from over a century of research) reported they changed sexual attraction or behavior, and some (from a small number of studies) said they were harmed: pp. 49, 85. No studies reporting harm met task force scientific standards: p. 42. The APA task force used the reports of harm as anecdotal evidence and based its recommendations on them. The researchers said one of the “key” “findings in the research” on which it “built” its “conclusions” and “recommendations" was that sexual attraction does not change through life experience: pp. 63, 86. If that were true, sexual attraction could not change through therapy. The *APA Handbook of Sexuality and Psychology* concluded 5 years later, however, that research had established that same-sex attraction, fantasies, behavior, and orientation identity all commonly change through life experience for men and women, adolescents and adults (2014, vol. 1, pp. 636, 562, 619).

[67] APA Task Force (2009), p. 86.

[68] Sexual orientation changes over the life span.

American Psychological Association’s *APA Handbook of Sexuality and Psychology* (2014):

- “[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.”

(Diamond, 2014, in *APA Handbook*, v. 1, p. 636)

- “Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation.”

(Rosario & Schrimshaw, 2014, *APA Handbook*, v. 1, p. 562)

- “Over the course of life, individuals experience the following:…changes or fluctuations in sexual attractions, behaviors, and romantic partnerships.”

(Mustanski, Kuper, & Greene, 2014, in *APA Handbook*, v. 1, p. 619.)

Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association.

[69] MEDICAL AND MENTAL HEALTH PROFESSIONAL ORGANIZATIONS have opposed bans on therapy that is open to a client’s goal of change for an unwanted sexual orientation or unwanted gender identity and/or supported the right of clients to such therapy for unwanted same-sex attractions and/or unwanted gender identity (https://iftcc.org/?s=organisations):

- International Federation for Therapeutic and Counseling Choice (https://iftcc.org/standards/)
- International Federation of Catholic Medical Associations (FIAMC) — **has 62 member organizations around the world**
- American Association of Physicians and Surgeons (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/
- American College of Pediatricians (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth
- Christian Medical and Dental Association (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://cmda.org/position-statements/
- Catholic Medical Association (USA) (https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf ; https://www.cathmed.org/resources/cma-protests-california-bill/
- Society of Catholic Social Scientists,
- Alliance for Therapeutic Choice and Scientific Integrity (https://docs.wixstatic.com/ugd/ec16e9_1d6108cfa05d4a73921e0d0292c0bc91.pdf
- American Association of Christian Counselors (AACC Code of Ethics, 2014, 1-120f, 1-330, 1-340, https://www.aacc.net/code-of-ethics-2/

Has defended the legal right to therapy conversations to resolve gender incongruence: National Association of Practicing Psychiatrists (Australia, https://napp.org.au/2021/05/managing-gender-dysphoria-incongruence-in-young-people-a-guide-for-health-practitioners/)

[70] Excerpt from the 11th Circuit Court decision (repeated from previous footnote):

> Defendants say that the ordinances “safeguard the physical and psychological well-being of minors.” Together with their amici, they present a series of reports and studies setting out harms. But when examined closely, these documents offer assertions rather than evidence, at least regarding the effects of purely speech-based SOCE. Indeed, a report from the American Psychological Association, relied on by the defendants, concedes that “nonaversive and recent approaches to SOCE have not been rigorously evaluated.” In fact, it found a “complete lack” of “rigorous recent prospective research” on SOCE. As for speech-based SOCE, the report notes that recent research indicates that those who have participated have mixed views: “there are individuals who perceive they have been harmed and others who perceive they have been benefited from nonaversive SOCE.” What’s more, because of this “complete lack” of rigorous recent research, the report concludes that it has “no clear indication of the prevalence of harmful outcomes among people who have undergone” SOCE. We fail to see how, even completely crediting the report, such equivocal conclusions can satisfy strict scrutiny and overcome the strong presumption against content-based limitations on speech.
>
> Still, they say, our confidence should not be shaken: the “relative lack of empirical studies on SOCE is not evidence of lack of harm….If anything, the lack of studies on SOCE may be indicative of the risk of harm.” The district court agreed: “Requiring Defendants to produce specific evidence that engaging in SOCE through talk therapy is as harmful as aversive techniques would likely be futile when so many professional organizations have declared their opposition to SOCE.” **In other words, evidence is not necessary when the relevant professional organization are united.**
>
> But that is, really, just another way of arguing that majority preference can justify a speech restriction. The “point of the First Amendment,” however, “is that majority preferences must be expressed in some fashion other than silencing speech on the basis of its content.” Strict scrutiny cannot be satisfied by professional societies’ opposition to speech. **Although we have no reason to doubt that these groups are composed of educated men and women acting in good faith, their institutional positions cannot define the boundaries of constitutional rights. They may hit the right mark—but they may also miss it.**
>
> **Sometimes by a wide margin too. It is not uncommon for professional organizations to do an about-face in response to new evidence or new attitudes….**

Otto, et al v. City of Boca Raton, FL et al., emphasis added:
Press release: https://lc.org/newsroom/details/112020-court-of-appeals-strikes-down-fl-counseling-ban-1
The legal decision: https://lc.org/PDFs/Attachments2PRsLAs/112020Otto.pdf

[71] MULTIPLE MEDICAL GROUPS THROUGHOUT THE WORLD have warned against “gender affirmative’” interventions, including the:

- Royal College of General Practitioners
- Swedish Pediatric Society
- Royal Australian College of Physicians
- National Association of Practicing Psychiatrists (Australia)
- Society for Evidence Based Gender Medicine (international)
- Pediatric and Adolescent Gender Dysphoria Working Group (international)

The Royal College of Psychiatrists has refused a position statement that would oppose psychotherapy or psychiatric treatment to resolve gender dysphoria.

See also these international groups:
gdworkinggroup.org
Society for Evidence-Based Medicine

[72] **Therapy bans prohibit therapy conversations. Instead, they promote medical body altering interventions.**

WHAT IS THE QUALITY OF THE “BEST AVAILABLE RESEARCH” THAT IS USED TO CLAIM MEDICAL GENDER AFFIRMATIVE PUBERTY BLOCKERS, CROSS SEX HORMONES, AND SURGERIES ARE “EVIDENCE BASED” INTERVENTIONS BASED ON “THE BEST AVAILABLE EVIDENCE”?

National forerunners in gender affirming interventions—The Netherlands, Sweden, the UK, and Finland—now place restrictions and prohibitions for minors on medical gender affirmative interventions due to very low quality of research.

The Endocrine Society Guideline with its 6 co-sponsoring organizations, including the World Professional Association for Transgender Health, say nearly all their recommendations are based on low, very low, and no research. A US government research review found research evidence to be “inconclusive”. A UK government review found the research quality to be “very low certainty evidence.”

SWEDEN POLICY CHANGE FOR MINORS:
Karolinska Universitetssjukhuset Astrid Lindgrens Barnsjukhus (March 2021). Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria at Tema Barn-Astrid Lindgren Children’s Hospital. Swedish: https://segm.org/sites/default/files/Karolinska_Policy_Statement_Swedish.pdf ; Unofficial English translation: https://segm.org/sites/default/files/Karolinska%20_Policy_Statement_English.pdf

UNITED KINGDOM:
HIGH COURT CASE FOR MINORS: Bell et al. v. Gender Identity Development Service at the Tavistock and Portman NHS Foundation Trust et al. (Decision 1 Dec. 2020). Neutral Citation Number: [2020] EWHC 3274. Case No: CP/60/2020. https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
GOVERNMENT RESEARCH REVIEW found evidence for puberty blockers provided “very low certainty evidence”. (p. 46)
The National Institute for Health and Care Excellence (NICE) (March 11, 2021). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphhoria. https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31

FINLAND ON MINORS:
Council for Choices in Health Care in Finland (COHERE Finland) (June 16, 2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation. https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abedfae46f2e/Summary_minors_en.pdf

THE NETHERLANDS:
de Vries, A.L.C. & Cohen-Kettenis, P.T. (2012). Clinical management of gender dysphoria in chiildren and adolescents: The Dutch approach. Journal of Homosexuality, 59, 301-320. http://www.hbrs.no/wp-content/uploads/2017/05/Clinical-Management-of-Gender-Dysphoria-in-Children-and-Adolescents-The-Dutch-Approach.pdf

ENDOCRINE SOCIETY GUIDELINE WITH 6 CO-SPONSORING PROFESSIONAL ORGANIZATIONS:
Co-sponsoring Associations with the Endocrine Society: Amer. Assn. of Clinical Endocrinologists, Amer. Soc. of Andrology, Eur. Soc. for Pediatric Endocrinilogy, Eur. Soc. of Endocrinology, Pediatric Endocrine Soc., and World Prof. Assn. for Transgender Health.
Hembree, W., Cohen-Kettenis, P., Gooren, L., Hannema, S., Meyer, W., Murad, M., Rosenthal, S., Safer, J., Tangpricha, V., & T’Sjoen, G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinolology and Metabolism, 102, 1–35. https://doi.org/10.1210/jc.2017-01658

UNITED STATES GOVERNMENT RESEARCH REVIEW:
Centers for Medicare & Medicaid Services (August 30, 2016). Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), p. 62, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282 .

[73] **The report to the Human Rights Council (HRC) within the United Nations (UN)** of the independent “expert” individual does not represent the views of the HRC or of the UN. UN Member States, in fact many, opposed his appointment and have said they don’t recognize his mandate. In fact, there is no binding UN agreement regarding sexual orientation or gender identity at all. Treaty body monitoring committees have tried to read sexual orientation and gender identity rights into existing treaties, but their pronouncements are not binding and are often opposed by States. Some individuals and organizations have incorrectly represented the independent individual “expert’s” report as a statement by the HRC or by the UN. The following reference is to a resolution by 57 Islamic nations documenting, by example, that many UN member states reject the mandate and the report of an individual “expert” who opposes change-exploration therapy for sexual and gender feelings and behaviors. To put this rejection by at least 57 states in perspective, the UN has 193 member states. The HRC has 47 member states.

OIC/CFM-43/2016/CS/RES/FINAL. Annex 1: Declaration by the
Group of the OIC Member States in Geneva on Condemning the Human Rights Council Resolution “Protection against violence and discrimination based on Sexual Orientation and Gender Identity”, pp. 68-69;
Resolution No. 4/43-C on
Social and Family Issues Submitted to The Forty-third Session of the Council of the Foreign Ministers of the Organization of Islamic Cooperation (Session of Education and Enlightenment: Path to Peace and Creativity) held in Tashkent, Republic of Uzbekistan, on 18-19 October, 2016 (17 – 18 Muharram 1438H), pp. 19-20. https://www.oic-oci.org/subweb/cfm/43/en/docs/fin/43cfm_res_cs_en.pdf

Organisation of Islamic Cooperation (OIC): History.
“The Organisation of Islamic Cooperation (OIC) is the second largest organization after the United Nations with a membership of 57 states spread over four continents.”
https://www.oic-oci.org/page/?p_id=52&p_ref=26&lan=en

[74] Testimonies of change through therapy or faith-based ministries:
VoicesOfChange.net.
X- Out-Loud.com
ChangedMovement.com.
FreeToChange.org/ex-lgbt-stories-of-change/.
ExodusGlobalAlliance.org/firstpersonc7.php.
ExodusGlobalAlliance.org/testimoniesc877.php.
Man describes his process of change through conversion therapy:
YouTube.com/watch?v=PCMOz2qzF_M.
TwoPrisms.com.
LifeSiteNews.com/news/watch-ex-gay-begs-canadian-politicians-to-not-ban-therapy-that-freed-him-from-lgbt-lifestyle?inf_contact_key=1ac10ff463ccc1d27f3272bddd06b-ca409c74070ac2bf3cfa7869e3cfd4ff832.
SexChangeRegret.com.
Tranzformed.org.
Transgender Transformed.
Testimony of an adolescent’s therapist choice and behavior change for religious reasons: here.