Oppose "Conversion Therapy" Ban

Serious Harms of Censoring Therapy Conversations

Dear Legislator,

PLEASE CONSIDER THIS EVIDENCE: Right to Health and Happiness (2 pp.)

(1) **The Supreme Court of the United States[1] and the U.S. 11th Circuit Court[2] say professional therapist speech has the same right to freedom of speech as other speech.**

(2) Comprehensive research reviews by gay-affirming[3] and change-exploring[4] researchers both accept that research participants reported **they changed same-sex attraction and behaviour 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. U.S. federal district[5] and 11th Circuit[6] courts cited the same**.

(3) An American Psychological Association task force: (i) Did *not* declare change-exploring therapy unethical. **(ii) Said aversive methods have <u>not</u> been used for 40-50 years.[7]** (iii) Said it based its recommendations on one-sided, anecdotal, not scientific, evidence.[8]

(4) Replicated, randomized, controlled trials published by gay-affirming researchers in peer-reviewed journals show men **can effectively decrease casual same-sex behavior significantly and lastingly through standard therapies or peer support** to reduce HIV transmission, especially so for men who have children.[9] A therapy ban must allow help to decrease same-sex or gender incongruent behavior that is unsafe or unlawful. If it does so, it should allow anyone this help for whatever reason they wish, without discrimination. It is next to impossible for a therapist to help someone reduce behavior while assuring the desire to engage in it is maintained and does not decrease. Behavior and the desire to engage in it are inseparably linked, and therapists help people change behavior by decreasing their desire to engage in it. A therapy ban **must allow anyone help to decrease whatever same-sex or gender incongruent behavior they wish and the desire to engage in it for whatever reason they wish, without discrimination.** Most who have same sex attraction are also attracted to the opposite sex, according to the *APA Handbook of Sexuality and Psychology*,[10] and most who are in a relationship are with the opposite sex.[11] **Some want this help to save their family**.

(5) **Many professional organizations support change-exploring therapy conversations[12] and several oppose body altering gender affirmation.[13] A professional consensus against therapy conversations does not in fact exist.** Shifting professional guild opinions now claiming consensus have been wrong, as the 11th Circuit Court decision highlights.[14]

(6) 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.[15] [16] [17] [18] [19] [20] **They can change.**
(7) <u>Childhood gender dysphoria overwhelmingly resolves by adulthood if minors are supported through puberty.[21] [22] Living as the opposite sex and puberty blockers stop natural resolution.[23]</u>

(8) **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.**[24] Research and professional organizations agree that incongruent gender identity is also caused by a mixture of biological and environmental influences[25] [26]— **like other unchosen, complex traits therapists help people diminish/change every day.**

9) **Psychiatric disorders and suicidality usually EXIST BEFORE onset of gender incongruence. Psychiatric disorders cause 90% of suicides.**[27] **Treating psychiatric disorders resolves suicidality and may resolve gender incongruence. Large, robust studies show cross-sex hormones and surgeries do not resolve mental disorders or suicidality.**[28] [29] [30] **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 BEFORE gender incongruence, compared to 3% to 4% of sex accepting peers. In the 6 months BEFORE first medical evidence of gender incongruence, depression was 23 to 24 times higher, and suicidal ideation 45 to 54 times higher.[31] These conditions that pre-exist thoughts about gender cannot be solely or usually caused by gender minority stress, stigma, or change-exploration therapy. But psychiatric disorders can lead to rejecting ones sex and adapting a different identity, according to the **World Prof. Assoc. for Transgender Health,**[32] **British Psych. Society,**[33] **and American Psychiatric Assoc.**[34] **Then body-altering procedures are not recommended. Banning therapy conversations to resolve gender dysphoria leaves little help.**

(10) **The American Psychological Association's *APA Handbook of Sexuality and Psychology***[35] **and research say family factors**[36] [37] [38] **and childhood sexual abuse**[39] [40] **may be causal factors** in having same-sex partners for some, and family pathology[41] [42] may be a causal factor for transgender identity for some. Some clients want to explore these causes and heal. There is no reason why this therapy should be less safe or effective than any other therapy. A ban will deprive patients of much needed therapy conversations.

(11) **Cross sex hormones and surgeries sterilize children**[43] **and lead to** 2-2.5 times higher rates of deaths from cancers, strokes, and heart attacks, 19 times higher rate of completed suicides—[44] [45] potentially a shorter life. Long term, it is *not* transgender health and is *not* suicide prevention.[46] Yet psychiatric hospitalizations still persist at a 2.8 times higher rate.
(12) **Sterilizing children**[47] **should be illegal, not therapy conversations.**

Government should not decide who someone is, what will make a person happy, and who may have access to much needed therapy conversations. Everyone should have the right to walk away from sexual or gender practices and experiences that don't work for them and have help to live the way that brings them health and happiness.[48]

Testimonies of change: **Here** and VoicesOfChange.net and more at this endnote:[49].
This letter with its endnotes giving more info and references: TherapyEquality.org/HarmsOfTherapyBans.

Sincerely, *Laura Haynes, Ph.D.,* Chair of Research and Legislative Policy, Representing the National Task Force for Therapy Equality, research@TherapyEquality.org; P.O. Box 653, Tustin, CA 92781.

MORE INFO & REFERENCES at TherapyEquality.org/HarmsOfTherapyBans
Or see the following endnotes.

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 U.S. 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 City of 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] “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.

[4]**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

[5] 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.

[6] 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.
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> 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.
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> 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.
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> 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

[7] APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009).
40-50 yrs—since about the 1960’s or 1970’s: pp. 22, 82.

[8]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).

[9]Several peer-reviewed scientific articles have documented that casual same sex behavior can be significantly reduced through therapy. Standard therapies, culturally adapted standard therapy, and a peer support group with lay counselling have all been demonstrated in replicated, randomized, controlled trials to significantly decrease casual same sex behavior (number of same sex partners) by nearly a half to virtually three-quarters (on average, so decrease was even greater for some) and maintain gains at 6 months, 8 months, and/or 1 year follow up. Taking the studies together, a range of ethnic groups, levels of education, and incomes was represented. This research was conducted by gay affirmative researchers to help men who have sex with men decrease drug use and risky sexual behavior with the goal of reducing HIV transmission. One of these studies found that men who have children and men who have a negative view of men having sex with men were particularly successful at decreasing casual same-sex behavior. (Nyamathi et al., 2017)

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. doi:10.1016/j.jsat.2007.11.004 ;https://europepmc.org/article/MED/15845315
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. https://ucdavis.pure.elsevier.com/en/publications/behavioral-treatment-approaches-for-methamphetamine-dependence-an

[10] Some lawmakers may assume that everyone who is attracted to the same sex would be happier in a same sex relationship. This is an invalid assumption. The *APA Handbook of Sexuality and Psychology* (2014) says, “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 also has been found internationally. (Tolman & Diamond, *APA Handbook*, vol. 1, p. 633)

[11] Many same sex attracted individuals are in opposite sex relationships. The definitive document in the U.K. found that 31 percent of LGB identified individuals in the United Kingdom were married in 2017, two-thirds of them to the opposite sex. (ONS, 2017) In the U.S., a nationally representative study found that, among bisexuals who were in any committed relationship, the vast majority were in an opposite sex relationship (86 percent of bisexual men and 73 percent of bisexual women who were in a committed relationship). (Herek et al., 2010, calculated from Table 8)

Office of National Statistics (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*, 2017, p. 10, Figure 5. Sexual orientation, UK.pdf. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/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

[12] 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 65 member organizations around the world**
- International Network of Orthodox (Jewish) Mental Health Professionals
- 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 (U.S.A.) (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/

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

- Royal College of General Practitioners
- Swedish Pediatric Society
- Royal Australian College of Physicians
- Society for Evidence Based Gender Medicine (international)
- Pediatric and Adolescent Gender Dysphoria Working Group (international)
- Youth Trans Critical Professionals (U.S.)

[14] 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.
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Otto, et al v. City of Boca Raton, FL et al., emphasis added:
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The legal decision: https://lc.org/PDFs/Attachments2PRsLAs/112020Otto.pdf

[15] *APA Handbook, 1*:636, 562, 619.

[16] 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.

[17] 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.

[18] Mock, S. E., & Eibach, R. P. (2012). Stability and change in sexual orientation identity over a 10-year period in adulthood. *Archives of Sexual Behavior, 41*, 641–648. doi:10.1007/s10508-011-9761-1

[19] In a study of sexual identity, defined by sexual attraction, in young adults over about 6 years, 43% of men and 50% of women experienced a shift in their sexual attraction, mostly one step along a scale that ranged from exclusively homosexual, to mostly homosexual, to bisexual (equally attracted to both sexes), to mostly heterosexual, to exclusively heterosexual. Among those who experienced any change, 66% of men and 66% of women changed to exclusively heterosexual. Among bisexuals, 75% changed, mostly toward or to exclusively heterosexual. Some exclusively homosexual individuals did change to develop opposite-sex attraction, even exclusively heterosexual attraction (males: 7% to exclusively heterosexual + 2% to bisexual = 9% changed; lesbians: 13% to exclusively heterosexual + 6% to mostly heterosexual + 8% to bisexual = 27% changed). Fewer exclusively heterosexual men (3%) and women (11%) changed, mostly to mostly heterosexual. (Calculated from Figure 1.)
Even a partial change can change a life and enable someone to live the life they desire. Categorical change to exclusively heterosexual is not required.
There are factors that are leading to these changes, obviously, and researchers, therapists, and clients should, in principle, be able to discover these factors.
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*, 103-110. https://link.springer.com/article/10.1007/s10508-012-9913-y

[20] Dickson, N., Roode, T., Cameron, C., & Paul, C. (2013). Stability and change in same-sex attraction, experience, and identity by sex and age in a New Zealand birth cohort. Archives of Sexual Behavior, 42, 753– 763. https://link.springer.com/article/10.1007/s10508-012-0063-z

[21] Hembree, et al., (2017), p.11. DSM-5, p. 455. APA Handbook, 1:744, 750.
Cohen-Kettenis P, Delemarre-van de Waal, H., & Gooren L. (2008), The treatment of adolescent transsexuals: Changing insights, J Sex Med, 5:1892–1897, DOI: 10.1111/j.1743-6109.2008.00870.x)
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*, pp. 2-3, 11, https://doi.org/ 10.1080/15532739.2018.1468293)

[22] Laidlaw, M. (Oct. 24, 2018), The gender identity phantom, http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/

[23] APA Handbook of Sexuality and Psychology (2014), vol. 1, p. 750. Hembree, et al. (2017), p. 11.

[24] 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

[25] At least 14 professional organizations around the world, including 10 endocrine societies internationally, agree that incongruent gender identity develops from a mixture of biological influences and life experiences in the social environment: 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 (Hembree et al., 2017) and in addition the Asian Pacific Pediatric Endocrine Society, Japanese Society of Pediatric Endocrinology, Sociedad Latino-Americana de Endocrinologia Pediatrica, Chinese Society of Pediatric Endocrinology and Metabolism (Lee et al., 2016), American Psychological Association (Bockting 2014, vol. 1, p. 743), American Academy of Pediatricians (Rafferty, 2018, p. 4), and British Psychological Society (2012, p. 25).
Hembree, W., et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guildeline. J Clin Endocrinol Metab,102:1–35, https://academic.oup.com/jcem , p. 6-7.
The American Psychological Association’s *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, 1: 743-744, 750.
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.
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)*: e20182162. P. 4, see also p. 4.

[26] Identical twins share the same genes, prenatal hormones, and number of older brothers. Identical twins are always the same sex. Sex is 100% determined by genes and prenatal hormones. But if one twin comes to have LGB experiences, discordant gender identity, or discordant gender expression, the other usually does not. This shows that influences other than genes or prenatal hormones are predominant causal factors.
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

[27]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

[28] “Gender affirming” hormone blockers, hormones, and surgeries do not reduce medical visits or prescriptions for depression or anxiety, or hospitalizations following suicide attempts, according to a study of transgender individuals in the entire Swedish population. This study published by the official journal of the American Psychiatric Association gives us the largest data set on long term outcomes.
Branstrom, R. & Pachankis, J.E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. *American Journal of Psychiatry 177(8)*:727-734. See Abstract. See Addendum and Correction to original 2019 publication to the article. https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2019.19010080
The label for the puberty blocker drug, Lupron, that is being given to gender distressed children, cautions providers to “monitor for development or worsening of psychiatric symptoms. Use with caution in patients with a history of psychiatric illness.”
Lupron Depot-PED (2017). Important new update to the prescribing information for Lupron Depot-PED (leuprolide acetate for depot suspension) injection, powder, lyophilized, for suspension. http://lupron.com/Content/pdf/LUPRON_DEPOT-PED_Label_Change_Highlights.pdf

[29]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.

[30]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.

[31] 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/

[32] **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

[33] **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%20for%20Psychologists%20-Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20(2012).pdf

[34] **The American Psychiatric Association** Task Force on the Treatment of Gender Identity Disorder noted gender dysphoric adolescents should be "screened for trauma as well as for any disorder (such as schizophrenia, mania, 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."
Byne, W., Bradley, S.J., Coleman, E., et al. (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

[35] 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

[36] 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 groups.
But not significant for Q youth, p. 3.

LGBTQ youth 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 are 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).

[37] *APA Handbook of Sexuality and Psychology* (2014), vol. 1, p. 583

[38] Absence of a parent, especially the parent of the same-sex as the child, is a small but significant and potentially causal factor found internationally for same-sex attraction, behavior, and marriage found in several large, robust, population-based, prospective, longitudinal studies 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

[39] 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

[40] *APA Handbook of Sexuality and Psychology* (2014), vol. 1, pp. 609-610

[41] TRANSGENDER IDENTITY MAY HAVE PATHOLOGICAL CAUSES:
The American Psychological Association’s *Handbook of Sexuality and Psychology* says transgender identity has psychological causes and may be pathological. It also says affirmative treatment may neglect individual problems gender dysphoric minors are experiencing.
APA Handbook of Sexuality and Psychology (2014), vol. 1, pp. 743-744, 750.

[42] 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 groups.
But NS for Q youth. p. 3.

LGBTQ youth more likely to experience psychological and/or physical abuse that may have included witnessing domestic violence (p. 4) and polyvictimization (relatively high probabilities for all adverse experiences, p. 5).

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 are generally confounded with gender nonconformity. However, this study may be the first that 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, and particularly transgender identified biological boys) had experienced more types of adverse experiences. Gender nonconformity, however, was not the only explanation for adverse experiences. p. 7.

[43] **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_jITfJZUUm1w/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://fenway-health.org/wp-content/uploads/Informed-Consent-for-Puberty-Suppression-4-2019.pdf

[44] 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.

[45] 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.

[46] 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.

[47] (Repeated content of a previous endnote.)

To be clear, “gender affirming” medical treatments sterilize and decrease sexual function. Los Angeles Children’s Hospital says,

> **i.**“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)
>
> **ii.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)
>
> **i.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_jITfJZUUm1w/view?usp=sharing

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 (no date “a”). Informed Consent for Feminizing Hormone Therapy. https://fenwayhealth.org/wp-content/uploads/Consent_Form_for_Feminizing_Therapy.pdf

Fenway Health (no date “b"). Informed Consent for Masculinizing Hormone Therapy. https://fenwayhealth.org/wp-content/uploads/Consent_Form_for_Masculinizing_Therapy.pdf

Fenway Health (2019). Informed Consent Form for Puberty Suppression. https://fenwayhealth.org/wp-content/uploads/Informed-Consent-for-Puberty-Suppression-4-2019.pdf

[48] Here are common reasons people want change-exploring therapy: (1) They identified as LGBTQ and had LGBTQ experiences, but ultimately they did not find it fulfilling. (2) They feel their LGBTQ attractions or behaviors were caused by trauma, and they want the right to heal. (3) They want to live according to their beliefs or ethics that bring them happiness. (4) They want to save their marriage and family and go on raising their children as a full-time mom or dad. Or they aspire to procreate children with a future spouse and raise them together. Those who seek therapy, not the state, should choose who gets therapy and for what reasons. We urge the state not to support discrimination over who can get help and what help they can get.

[49] Testimonies of change through therapy or faith-based ministries: VoicesOfChange.net, ChangedMovement.com, https://www.exodusglobalalliance.org/firstpersonc7.php , https://www.exodusglobalalliance.org/testimoniesc877.php , SexChangeRegret.com, tranzformed.org,Transgender Transformed.