

Submission to Victor Madrigal-Borloz Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity.

For consideration towards a Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity with focus on practices of so-called “conversion therapy” to the 44th Session of the Human Rights Council.

**From: The International Federation for Therapeutic and Counselling Choice
(Science and Research Council)**

Contributors: Davidson, M.R., PhD; Rosik, C.H., PhD; Moseley, C., PhD and Haynes, L., PhD. [21 December 2019]

Question 1

What different practices fall under the scope of so-called “conversion therapy” and what are the common denominators that allow their grouping under this denomination?

Not unlike the term “Sexual Orientation Change Efforts” (SOCEs), “Conversion Therapy” is an imposed, pejorative term that confuses unethical practices with psychotherapeutic and counselling approaches used to explore sexual attraction fluidity in therapy (SAFE-T). SOCE wrongly implies that all therapists were imposing an agenda on clients and that the effort was located in therapists’ interventions, when in reality therapists support autonomous individuals who seek change for unwanted attractions. “Conversion Therapy” is a catch-all term conflating unethical practices with exploration of sexual fluidity issues respectful of client self-determination.

Douglas C. Haldeman first used the term ‘conversion therapy’ in 1991¹. In the first page of this book chapter he failed to distinguish between psychotherapy and counselling on the one hand, and psychiatry on the other. This led to putting the published findings of psychoanalytic psychotherapeutic work by Irving Bieber² with voluntary clients in the USA in the mid-twentieth century (pp. 150-151) alongside the published work of Desmond Curran and Denis Parr³ published in 1957 on a British sample of 100 male clients, 30 of whom were referred due to being convicted of homosexual sex offenders, 22 due to having psychiatric problems and 12 due to pressure from friends or relatives. It is evident from reading Curran and Parr’s paper that many of the clients under consideration had little intrinsic motivation to pursue change in sexual attraction. As such it should be of little surprise that most did not experience any significant degree of change. Also relevant - and ignored by Douglas Haldeman - is the fact that as many as 17 of the 100 clients were paedophiles, i.e. attracted to pre-pubescent boys, out of these 12 were not attracted to adult males. It is implausible to suppose that such pedophiles would be motivated to develop an interest in adult females.

As the Alliance for Therapeutic Choice and Scientific Integrity (2012) notes:

1 Douglas C. Haldeman, (1991). Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 149-160). Thousand Oaks, CA, US: Sage Publications, Inc. <http://drdoughaldeman.com/doc/ScientificExamination.pdf>

Douglas C. Haldeman, The Practice and Ethics of Sexual Orientation Conversion a Therapy, *Journal of Consulting and Clinical Psychology*, v62 n2 p221-27 Apr 1994. <http://www.drdoughaldeman.com/doc/Practice&Ethics.pdf>

2 Irving C. Bieber, *Homosexuality: A Psychoanalytic Study of Adult Male Homosexuals*. New York: Basic Books, 1962.

3 Desmond Curran and Dennis Parr, ‘Homosexuality: An Analysis of 100 Male Cases Seen in Private Practice’, *British Medical Journal*, April 6, 1957, 797-801. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1973178/pdf/brmedj03149-0031.pdf>

Much of the expressed pessimism regarding sexual orientation change is a consequence of individuals intentionally or inadvertently adopting a categorical conceptualization of change. When change is viewed in absolute terms, then any future experience of same-sex attraction (or any other challenge), however fleeting or diminished, is considered a refutation of change. Such assertions likely reflect an underlying categorical view of change, probably grounded in an essentialist view of homosexual sexual orientation that assumes same-sex attractions are the natural and immutable essence of a person. What needs to be remembered is that the delegitimizing of change solely on the basis of a categorical view of change is virtually unparalleled for any challenge in the psychiatric literature. For example, applying a categorical standard for change would mean that any subsequent reappearance of depressive mood following treatment for depression should be viewed as an invalidation of significant and genuine change, no matter how infrequently depressive symptoms reoccur or how diminished in intensity they are if subsequently re-experienced. Similar arguments could be made for any number of conditions, including grief, alcoholism, or marital distress. The point is not to equate these conditions with homosexuality, but rather to highlight the inconsistency of applying the categorical standard only to reported changes in unwanted same-sex attractions.

We request FIRST that the report to be tabled at the 44th Session of the Human Rights Council distinguish between the legitimate notion of exploring sexual attraction fluidity in therapy (SAFE-T) sessions with professional therapists and counsellors, and practices forcing, guaranteeing or offering unrealistic goals of categorical change thereby implying notions of absolute change. This distorts sound and valid exploration of sexual attraction fluidity exploration in therapy, fully cognizant with the biographical journeys individuals share with their therapists, including the traumas they may have suffered.

Question 2

Are there definitions adopted and used by States on practices of so-called “conversion therapy”? If so, what are those definitions and what was the process through which they were created or adopted?

Because the IFTCC is registered in Great Britain⁴ we make reference to an important example of the lack of ideological diversity and the viewpoint discrimination that has allowed the UK Government under Prime Minister Teresa May to ignore any research indicators contrary to state orthodoxy seeking to ban therapeutic choice in this document.

The UK Government’s Equalities Office Research Report (2018:83) is indicative of the UK Government’s position: “So-called conversion therapies, sometimes also referred to as cure, aversion or reparative therapies, are techniques intended to change someone’s sexual orientation or gender identity. These techniques can take many forms and commonly range from pseudo-psychological treatments to spiritual counselling. In extreme cases, they may also include surgical and hormonal interventions, or so-called ‘corrective’ rape.”⁵

Monocultures of political orthodoxy and the role of viewpoint discrimination

Internationally, definitions of “Conversion Therapy” are premised on one ideological viewpoint which fails to distinguish between legitimate exploration of sexual attraction fluidity in professional settings, and poor therapy. This leads to the denial of therapeutic choice, and of the use of change-allowing therapies for clients seeking to diminish attractions. It also leads to the imposition of therapists’ agendas compliant with the “change is not permissible or possible and is always harmful” viewpoint. Without ideological diversity in the process of achieving clarity about such subjects as

⁴ The International Federation for Therapeutic and Counselling Choice was registered in Great Britain, 11 August, 2017, Company Number 10910877 <https://beta.companieshouse.gov.uk/company/10910877>

⁵ **Research Report (2018:83)** <https://www.gov.uk/government/publications/national-lgbt-survey-summary-report>

therapeutic choice, monocultures of intolerance will develop as has already happened in the emergence of wanting to ban therapeutic choice.

Before examining specific instances where dissenting views are automatically excluded in the UK as we do in responding to question 3, there are additional concerns the 44th session of Human Rights Council at the United Nations might revisit by examining the Universal Declaration of Human Rights (UDHR) in relation to the proposed intention to restrict therapeutic choice.

1. Restriction is an attack on sex-based rights and dignity. Article 2 of the UDHR prohibits discrimination on grounds of sex

Sex is biological; we are all either male or female. There is a clash between the concept of gender identity and the protected characteristic of sex. Usually for someone to go down the path of an alternative gender identity means moving away from living and being known as a member of their biological sex.

2. Restriction discriminates against ex-LGBT people. Article 2 of the UDHR prohibits discrimination on grounds of ‘other status’

In UK case law ‘ex-gay’ is a protected characteristic under the Equality Act 2010. In one of the cases on this issue the then Minister for Women and Equalities intervened in favour of non-discrimination.

Just as with being straight without ever having experienced same-sex attraction or acted upon it, ex-gay can be a sexual orientation or also a sexual identity, meaning that it is a social descriptor used by the individual concerning him - or herself.

3. Restriction is an attack on freedom of speech. Article 18 of the UDHR protects freedom of thought, conscience and religion, and is used to protect freedom of speech

Therapeutic conversations are a private and confidential matter, though they may occur either in the public sector or the private sector. Restricting therapy would violate freedom of speech of both clients and therapists, as well as third parties such as supervisors of therapists. A situation would arise whereby a state had prohibited free speech on human sexuality, behaviour and feelings in private and confidential conversations as well as public settings, essentially because LGBT activists consider the words that might be said to be offensive.

Many counsellors and psychotherapists work from their own homes and may be self-employed. Other therapists may work over the internet or the telephone or use email. Restricting them would also effectively entail restrictions on therapists’ use of the internet, phone and all other means of electronic and remote communication.

4. Restriction is an attack on freedom of expression. Article 19 of the UDHR protects freedom of expression

Restrictions on therapy would count as attacks on freedom of expression of the individual client, the counsellor or therapist, his or her supervisor, any course lecturers, tutors or facilitators, as well as the freedom of expression of family members of the client.

Freedom of expression includes freedom to share one’s life-story, hopes, goals and feelings with others. It includes freedom to create and produce artistic material as well as sharing online content of all kinds. It includes freedom to express views which may even be subject to debate in society.

5. Restriction is an attack on freedom to receive and impart information. This is protected by Article 19 of the UDHR

This includes the freedom to ‘receive and impart information and ideas without interference by public authority and regardless of frontiers.’ Topics related to the therapies in question could not be discussed in public in a way that is comprehensive and takes different viewpoints seriously. Publications and material on this topic, especially those favourable to such therapies, could not be accessed online or offline.

Restricting therapy would effectively entail that no independent academic research conducted by those not agreeing with the views accepted by government could be conducted on the subject or related fields. Course material based on such research could not be published or taught. Thus, the freedom to access education would be violated. In an increasing number of countries today people are having to hide their desire to work in this field of therapy in order not to be thrown off training courses.

6. Restriction is an attack on freedom of assembly and association. Article 20 of the UDHR protects freedom of assembly and association

Restriction of therapy is an attack on the freedom of assembly including organisation of conferences, training events, group therapy, educational events, press conferences, showings of films and plays.

In February 2018 Core Issues Trust’s freedom of assembly was violated when the British LGBT news site Pink News managed to cancel the world premiere of the Trust’s feature-length documentary, ‘Voices of the Silenced’, featuring numerous therapists and clients. The film actually illustrates the restrictions already put in place by the UK government in the Memorandum of Understanding in that most clients and therapists interviewed are not British citizens or residents.

7. Restriction is an attack on freedom of conscience. Article 18 of the UDHR protects freedom of conscience

Many people choose to seek therapy to move away from LGBT identification for reasons of conscience. Many professionals in this field are also following their conscience in providing such services. It is important to state that not all of these clients or professionals would be religious. In recent years the misleading impression has arisen in the media that conscientious objection to same-sex sexual behaviour and transgender identification is only held by religious people, whereas in fact survey evidence suggests objections are more widely held.

To restrict access to therapies and the right to practise professionally to those affiliated with a religion would be to violate the rights of people of no religion, possibly a very large number of current and prospective clients.

8. Restriction is an attack on the right to respect for privacy, family life, home and correspondence. Article 12 protects the individual’s right not to be subjected to arbitrary interference with their privacy, family, home or correspondence

The right to respect for privacy, family, home and correspondence is intended to protect the individual from unwarranted state surveillance. Any restriction on therapy would violate this right. Both existing professional bans and state laws criminalising ‘conversion therapy’ effectively impose a system of surveillance in that they threaten professionals in this area with exclusion from the workforce if detected. This could easily lead to detection of clients and violation of their rights.

9. Restriction is an attack on the right to marry. Article 16 of the UDHR protects the right to marry

Some people want therapy in order to feel they are ready to pursue their personal life-goal of opposite-sex marriage. Therapy for issues around sexual identity, feelings and behaviour is a normal part of life in the western world today. Any restriction on therapies for unwanted same-sex attraction and gender identities would indirectly constitute a violation of the client's right to marry. It might also prevent a married person from finding help in preserving their marriage and family.

Restriction might also have an allied negative effect on the prospective spouses and relatives of the individual in question. It could also affect the production, publication and dissemination of material for marriage preparation courses.

10. Restriction is an attack on the freedom of religion. Article 18 of the UDHR protects freedom of thought, conscience and religion

Some clients seeking out therapies of this kind are affiliated to or belong to a religion. Their religious beliefs and commitments may be of help to them in moving out of LGBT identities and they may seek out professionals who are willing to respect their religious commitment in the therapeutic relationship.

We request SECOND that the Report submitted to the 44th Session of the Human Rights Council at the United Nations explains how imposing bans on therapeutic choice by insisting that change-allowing therapies may not be used in any circumstance is consistent with the Universal Declaration of Human Rights.

The process by which the UK Government, for example has arrived at its definition of "Conversion therapy" has lacked rigour because it has only included gay-affirming approaches and omitted the voices of formerly LGBTI identified persons. Rosik (2018:1) notes what has to be said about the research base referenced in the debate over sexual attraction fluidity exploration in therapy (SAFE-T) is that it is assuredly incomplete. It cannot credibly form the basis for public policy without the assistance of a politicized process whereby science follows rather than directs the formation of legislation. The socio-political commitments within organized psychology and among sexual orientation researchers in particular are essentially hegemonic and left-of-centre⁶. This viewpoint monopoly creates a serious problem for the scientific enterprise. As noted by Redding⁷ "The kind of science that gets conducted, how findings are interpreted and received, and the degree of critical scrutiny such studies receive is dependent upon scientists' socio-political views" (p. 439). Rosik has also outlined these concerns and their occurrence in recent ban legislation in California⁸

Problems with Research leading to Definitions of "Conversion Therapy"

First, the research into such therapy in the modern era is completely reliant on convenience samples, which are unable to make causative statements. Studies relying on such samples cannot tell us if any purported harm derives specifically from therapy or whether such harm is actually pre-existing distress that accompanied clients into their therapy. In what is likely to be a sign of confirmation bias, the anecdotal evidence of harm is touted as broadly conclusive by researchers and politicians supportive of bans, but these same individuals dismiss the anecdotal evidence of benefit.

Second, the research on SAFE-T is almost entirely conducted using participants who publicly identify as gay, lesbian, and bisexual recruited from GLB venues and social networks. This creates a bias in that those who may have benefited from such therapies are excluded from the outset as they

⁶ Duarte, J. L., Crawford, J. T., Stern, S., Haidt, J., Jussim, L., & Tetlock, P. E. (2015). Political diversity will improve psychological science. *Behavioral and Brain Sciences*, 38, 1-13. [http://www.rci.rutgers.edu/~jussim/Duarte et al, 2015, BBS, target, commentaries, reply.pdf](http://www.rci.rutgers.edu/~jussim/Duarte%20et%20al,%202015,%20BBS,%20target,%20commentaries,%20reply.pdf)

⁷ Redding, R. E. (2013). Politicized science. *Society*, 50, 439-446. <https://www.conservativecriminology.com/uploads/5/6/1/7/56173731/ssrn-id2344433.pdf>

⁸ Rosik, C. H. (2017). *Sexual orientation change efforts, professional psychology, and the law: A brief history and analysis of a therapeutic prohibition*. *BYU Journal of Public Law*, 32, 47-84. <https://digitalcommons.law.byu.edu/jpl/vol32/iss1/3>

often do not identify as gay or lesbian and do not generally associate with the gay community. Thus, these are studies that tend to vastly over sample accounts of harm. This situation is akin to examining the harms and benefits of marital therapy by using a sample restricted to former marital therapy patients who have since divorced. No government agency would consider such research sufficient for creating legislation regarding the practice of marital therapy.

Third, there is simply no incentive and much disincentive for conducting research from a position sympathetic to SAFE-T. The cases of Robert Spitzer or Mark Regnerus in the United States are sobering examples[5]. Researchers who provide findings in any way supportive of such therapy are denounced, professionally marginalized, investigated, cut off from future grant monies, and risk career threatening damage to their academic livelihoods. In such an environment, it is a minor miracle that research countering the preferred political narrative can even get published, though fortunately rare occurrences do happen[6].

We request THIRD that the Report submitted to the 44th Session of the Human Rights Council honestly reflects on the widespread refusal, internationally, to engage with dissenting views and beneficiaries of change-allowing therapies, those who identify as formerly LGBT, their therapists and the literature supporting their work.

Question 3

What are the current efforts by States to increase their knowledge of practices of so-called “conversion therapy”? Are there efforts to produce information and data on these practices?

On 3 July 2018, supported by the LGBT National Survey Report[9], the UK Government stated its intention, as one action point in its LGBT Action Plan[10], to ban “Conversion Therapy”. Its Summary Report states that no definition of “Conversion Therapy” was provided[11], but the Research Report’s working definition, (using inaccurate, misleading and defamatory language)[12] concludes that these are “techniques intended to change someone’s sexual orientation or gender identity”. In the ten points that follow, we argue that everyone has the right to walk away from sexual practices and experiences that don’t work for them and should be supported to do so.

1. **When referring to “Conversion Therapy” the LGBT National Survey Report makes no reference to the published literature** in the field nor to ideological diversity in research and debate, and as such represents “Advocacy Science”.

The fact is **there is no evidence of harm** from sexual orientation change therapy provided **There are also a great many studies supporting professional work** in this area [13][14][15][16]. Change therapy is talk therapy led by qualified therapists working with willing and motivated clients.

9 **National Survey Report:** <https://www.gov.uk/government/publications/national-lgbt-survey-summary-report>

10 **LGBT Action Plan 2018:** <https://www.gov.uk/government/publications/lgbt-action-plan-2018-improving-the-lives-of-lesbian-gay-bisexual-and-transgender-people>

11 **Summary Research Report 2018:14:** “We did not provide a definition of conversion therapy in the survey, but it can range from pseudo-psychological treatments to, in extreme cases, surgical interventions and ‘corrective’ rape”. <https://www.gov.uk/government/publications/national-lgbt-survey-summary-report/national-lgbt-survey-summary-report>

12 **Research Report (2018:83):** “So-called conversion therapies, sometimes also referred to as cure, aversion or reparative therapies, are techniques intended to change someone’s sexual orientation or gender identity. These techniques can take many forms and commonly range from pseudo-psychological treatments to spiritual counselling. In extreme cases, they may also include surgical and hormonal interventions, or so-called ‘corrective’ rape.” <https://www.gov.uk/government/publications/national-lgbt-survey-summary-report>

13 Karten, E. L., & Wade, J. C. (2010). Sexual orientation change efforts in men: A client perspective. *Journal of Men’s Studies*, 18, 84–102.

14 Spitzer RL. “Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Arch of Sexual Behavior*, Vol. 32, No. 5, Oct. 2003, pp. 403-417.

15 Homosexuality and the Politics of Truth, Jeffrey Satinover (Baker Books, 1996) pp. 179-195.

16 Successful Outcomes of Sexual Orientation Change Efforts, James E. Phelan (Phelan Consultants LLC, 2014).

2. **Governed by one ideological viewpoint**, the UK's Professional Mental Health bodies have for some time enforced a *de facto* ban on "Conversion Therapy". Public opinion appears to be ignored. Dissension on the matter is not tolerated within professional memberships. This entrenches a mono-culture and view-point discrimination is the result; enquiry research has ceased on the topic, neither can it attract funding, or published recognition by qualified professionals, in the literature [17] [18] [19] [20] [21]. This is what advocacy science ignores.
3. **The National LGBT Survey (2018) is flawed.** It is a volunteer online sample. Non LGBT - and implicitly ex-LGBT – were ineligible. It is not clear how non-UK and multiple respondents were eliminated. It did not define 'conversion therapy' but asked only if people had experienced it or been offered it, and by whom. It did not ask if the 'conversion therapy' was beneficial or harmful, nor the methods experienced. Policy and law based on this survey are therefore based on mere assumptions. For a more full discussion of this please refer to pp. 9-12 of "A Response to the UK Government's Intended Ban on Therapeutic Choice" (2018)²².
4. In UK society, ideological fault-lines separate those who conflate gender and sexual **fluidity**, from those who view sexuality as fluid and gender mostly as fixed. **Sexual Attraction Fluidity Exploration in Therapy (SAFE-T) is a valid and ethical response** to the extreme practices highlighted by the government's grab-all definitions.
5. **Evidence is being ignored that sexuality is not innate, and is not immutable.** This evidence includes population studies. The public is being denied right of access to counselling, based only on fears of "potential harm" and ideological preference.
6. Neither the Research Report of the National LGBT Survey, nor the LGBT Action Plan pay any attention to **questions of personal autonomy nor to the implications of the proposed ban implied in the European Convention on Human Rights.**
7. The state church, the Church of England, has urged the government to impose this ban. Using anecdotal evidence of only one type, and claiming spiritual abuse, they have done so without presenting *evidence* of harm or malpractice. **The church has actively refused audiences to listen to the testimonials of once-gay and ex-gay persons.** Neither have they shown discernment of legitimate counselling practice.
8. The then Prime Minister, the **Rt. Hon. Teresa May**^[23] and the Minister for Women and Equalities the **Rt. Hon. Penny Mordaunt**^[24] have referred to the "abhorrent practice of 'Conversion Therapy'". They have nevertheless **actively declined to meet individuals who claim to have benefited from counselling support for unwanted same-sex attractions and gender confusions**, thereby denying their identities.

¹⁷ Sexual Orientation Change Efforts Do Not Lead to Increased Suicide Attempts (Summary of excerpt from Whitehead, N.) (2010). Homosexuality and Co-Morbidities: Research and Therapeutic Implications. *Journal of Human Sexuality*, 2, 125-176).

¹⁸ A.D. Byrd, Joseph Nicolosi, and R.W. Potts (February 2008), "Clients' Perceptions of How Reorientation Therapy and Self-Help Can Promote Changes in Sexual Orientation," *Psychological Reports*, 102, pp. 3-28.

¹⁹ Nicolosi, J., Byrd, A. Dean, Potts, R.W. (June 2000), "Retrospective Self-Reports of Changes in Homosexual Orientation, A Consumer Survey of Conversion Therapy Clients". *Psychological Reports*, 86: 1071-1088.

²⁰ Nicolosi, Joseph, Byrd, D., Potts, R.W. (June, 2002). "A Meta-Analytic Review of Treatment of Homosexuality". *Psychological Reports* 90: 1139-1152.

²¹ Essential Psychopathology and Its Treatment, Third Ed, Maxmen, War, and Kilgus (W.W. Norton & Co.)

²² https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2018/10/IFTCR_Response_to_UK_Government_Ban_on_Therapeutic_Choice_v2.pdf?x80293 <18th December, 2019>

²³ **ITV News**, 3 July, 2018: <https://youtu.be/CNeaEosWxOK>

²⁴ 4 July, 2018 **Launch Event LGBT Action Plan: "The plan's commitments range from a national lead on healthcare, to banning the abhorrent practice of conversion therapy, to action on hate crime and combating bullying in our schools"**
<https://www.gov.uk/government/speeches/launch-event-lgbt-action-plan-2018>

9. **The UK government’s documentation does not appear to be aware that the unintended consequences of banning** counselling for unwanted same-sex attractions and gender confusion, may well lead to increased suicide attempts and completed suicides for this population group.

Even the *APA Handbook of Sexuality and Psychology*, which the American Psychological Association has declared “authoritative,”²⁵ says childhood sexual abuse has “associative and potentially causal links” to having same-sex partners for some, based on research that includes a 30 year study of documented cases of childhood sexual abuse.²⁶ It also says there are psychoanalytic causes of same-sex sexuality,²⁷ and family pathology may be a factor in transgender identity.²⁸ A rigorous 8 year cohort study found that 66 percent of adolescents experienced high rates of psychiatric disorders and hospitalizations in the 6 months leading up to onset of gender non congruence.²⁹ Even the World Professional Association for Transgender Health admits gender dysphoria may be “secondary to and better accounted for by other diagnoses.” And even WPATH does not recommend gender affirmative medical procedures in this case.³⁰ Forbidding psychotherapy or counseling for resolving gender dysphoria leaves few options. Psychotherapy or counseling for trauma or other mental disorders that may underly unwanted sexual and gender feelings and behaviours may resolve them, but failure to consider underlying causes and treat them can lead to ongoing trauma, mental disorders, or suicide. Research shows that 96% of adolescents who attempted suicide had a pre-existing mental disorder,³¹ and that, worldwide, 90% of people who completed suicide had mental disorders.³² A therapy ban requires affirming sexual or gender feelings or behaviors caused by trauma or psychiatric disorders and requires denying potential underlying pathological causes exist. But treatment for them is warranted and may result in diminishing or resolving unwanted sexual or gender feelings or behaviors.

10. **Labelling Therapeutic Choice “Extremism”.** Government officials have made the link between counselling which supports unwanted homosexual feelings and gender confusions as “non-violent extremism” as a means of suppressing legitimate counselling and the choice of clients seeking therapy or counselling.

We request FOURTH that the Report submitted to the 44th Session of the Human Rights Council notes the serious omission of data relating to those identifying as formerly LGBT and the dearth of evidence indicating that any research or care has been given to the needs of this subgroup of our populations.

Question 4

- ²⁵ Vandenberg, G. (2014), Series Preface, in Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology*, vol.1, p. xvi, Washington D.C.: American Psychological Association, <http://dx.doi.org/10.1037/14193-000>
- ²⁶ 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, *APA Handbook of Sexuality and Psychology*, Washington D.C.: American Psychological Association, vol. 1, pp. 609-610.
- ²⁷ Rosario, M. & Schrimshaw, E. (2014). Theories and etiologies of sexual orientation. In Tolman, D. & Diamond, L., Co-Editors-in-Chief (2014). *APA Handbook of Sexuality and Psychology*, Washington D.C.: American Psychological Association. V. 1, p. 583.
- ²⁸ Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology*, Washington D.C.: American Psychological Association, vol. 1, p. 743.
- ²⁹ Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. *Pediatrics*. 2018;141(5):e20173845
- ³⁰ World Professional Association for Transgender Health (WPATH) (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, <https://wpath.org/publications/soc>, p. 24.
- ³¹ Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslavsky, A., and Kessler, R. (2013), Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A), *JAMA Psychiatry*, 70(3): p. 18, Table 3, doi:10.1001/2013.jamapsychiatry.55.
- ³² Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003), Psychological autopsy studies of suicide: a systematic review, *Psychological Medicine*, 33: 395–405, Cambridge University Press, DOI: 10.1017/S0033291702006943

What kinds of information and data are collected by States to understand the nature and extent of so-called “conversion therapies” (e.g. through inspections, inquiries, surveys)?

The National Faith and Sexuality Survey (2018) was commissioned and reported on, not by the Government but by the Ozanne Foundation, an LGBT activist group. It is not to be confused with the Government’s National LGBT Survey which was carried out at around the same time.

The National Faith and Sexuality Survey 2018^[33] (FSS) is intended to influence church and public policy. It was a volunteer web-based survey open to all individuals living in the UK who were over 16. The sample is around 4% of the size of the National LGBT Survey^[34] and is not representative of the UK or the LGBT population, limiting its usefulness for statistical analysis. Ostensibly to examine the role religious belief has on people’s understanding and acceptance of their sexual orientation in the UK, it seems its real aim was to end religious support for change in sexual orientation, to which end it calls for ‘safeguarding’. It also aims to gain support for the criminalising of ‘sexual orientation change therapy’. Points of criticism include:

1. **The Office for National Statistics³⁵ estimates LGB are 2% of the UK population - an estimated 1,100,000 people aged 16+. In stark contrast, the FSS found 52% of its sample was LGBQ+. In Q23 11.37% (458 people) said yes, they had actual experience** of attempting to change their sexual orientation. Yet only 368 people gave any evidence of this experience in the subsequent branch of questions: too few to adequately examine something that could affect the lives of 1.1 million people^[36].
2. **The sample was also over-represented by a third in the age group 35-64 compared to the 2017 Office for National Statistics^[37] estimates of the UK population** and it was heavily biased towards Anglican Christians (41%). Taken together, these factors suggest that there is an ‘Ozanne brand’ which attracts a certain type of person who is motivated to respond in a particular way.
3. **FSS is partisan, and has errors in its design, with the effect that some key claims were not proven by the data.** Question 1 allowed 18 year olds to put themselves into either category of 16-18 or 18-24 years. This limited the examination of data by age. Some data items are listed twice in one table - with different values. There were significant issues of missing data and data integrity: the FSS appears to have used both complete and incomplete survey responses and data are presented as a % of those answering each question, with a different denominator for each question. This means that, as presented, data from different tables cannot be accurately compared to each other. The possible routes through the survey seem to have had failures. Key questions were missed by most participants (Q27, Q29 - ‘How long ago was this?’) People were routed into questions without explanation, swelling numbers (Q21, Q22, Q33).
4. **Most respondents were teenagers last century: 72.08% of the respondents were over 35 years old.** 511 respondents were aged 16-25. Just 67 people were 16-18 years old.

³³ 2018 National Faith & Sexuality Survey (Faith and Sexuality Survey) (FSS) Ozanne Foundation <https://ozanne.foundation/faith-sexuality-survey-2018/> National Faith & Sexuality Survey Responses - Full.pdf FSS 2018 Executive Report NFSS Sections 1-6

³⁴ National LGBT Survey Research Report July 2018 Government Equalities Office Reference: GEO – RR001 ISBN: 978-1-78655-671-4 www.gov.uk/government/consultations/national-lgbt-survey

³⁵ ONS: Sexual orientation, UK: 2017 <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017>

³⁶ SurveyMonkey’s online survey building software at: <https://www.surveymonkey.com/>

³⁷ Office for National Statistics (ONS): Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2017 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017> theanalysisofpopulationestimatestool2017

5. **Data from Q20-22 are the basis of a serious allegation – that religious leaders forced people to attempt to change their sexual orientation.**^{38,39} FSS fails to clarify when this happened, not even if this is a current problem or one of last century. The responses from Q22 contradict Q20 indicating a problem in data collection. It would be unjust to change church and society based on these flawed data.
6. **No data were presented to indicate the chronological year, decade or century wherein any attempt to change sexual orientation occurred, or the form of attempt used, or its impact - not even for teenage respondents.** Therefore current harm and the need for more safeguarding are not proven.
7. **Some of the 16 cited ‘forms of attempt’ to change sexual orientation used to be practised by the NHS.** [40],[41],[42],[43],[44],[45],[46] Some of these practices – abandoned for this purpose last century as unethical - could only ever have been practised by a registered doctor or psychiatrist^[37] Professional psychotherapy with the goal of sexual orientation change was banned in 2014 by public policy^{[47],[48]}, so the youngest are unlikely to have experienced this either. Also cited was forced sex – which is already addressed by the laws on rape. Other ‘forms of attempt’ included spiritual practices such as prayer, fasting, and healing with religious ministry, family or friends. To conflate all these⁴⁹ together was misleading and unhelpful. The implication that prayer and personal relationships should be controlled raises serious issues of religious and personal freedom.
8. **The reported figures for mental ill-health are within the range seen in similar volunteer online LGBTQ surveys not predicated on therapy.**^{[50],[51]} Degrees of self-harm, eating disorders, and suicidal thoughts/actions are comparable to the survey ‘Life in Scotland for LGBT Young People’ 2018^[52] and are therefore not caused by change therapy as claimed by the FSS survey promoters. Owing to survey design, the FSS fails to show an exclusive link between attempts to change sexual orientation and suicidal ideation and self-harm. Representative studies have shown that all LGB are at increased

³⁸ Latifa Yedroudj, Daily Express 13:09, Thu, Feb 21, 2019 ‘Gay Christians in UK forced to have straight sex in ‘gay cure therapies’ - shock survey’ <https://www.express.co.uk/news/uk/1090401/gay-christians-christianity-conversion-therapy-survey-poll>

³⁹ Steve Doughty Daily Mail 21 February 2019 ‘Gay people are being forced to have straight sex as part of ‘conversion therapy’ requested by religious leaders, Church survey reveals.’ <https://www.dailymail.co.uk/news/article-6726761/Gay-people-forced-straight-sex-religious-conversion-therapy.html>

⁴⁰ Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of patients. Glenn Smith, Annie Bartlett, Michael King 29 January 2004 BMJ, doi:10.1136/bmj.37984.442419.EE

⁴¹ The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation Annie Bartlett, Glenn Smith and Michael King 26 March 2009. BMC Psychiatry 2009, 9:11 doi:10.1186/1471-244X-9-11

⁴² Strudwick, Patrick BuzzFeed UK LGBT Editor 30 Sept 2017. This Gay Man Was Given Repeated Electric Shocks By British Doctors To Make Him Straight

⁴³ Strudwick, Patrick BuzzFeed UK LGBT Editor 16 October 2017 Psychiatrists Have Issued A Historic Admission Of The Harm Done By Aversion Therapy

⁴⁴ NHS England <https://www.england.nhs.uk/2017/12/1-4-million-people-referred-to-nhs-mental-health-therapy-in-the-past-year/>

⁴⁵ Making sense of Electroconvulsive therapy (ECT) MIND 2016

⁴⁶ Mental Health Foundation <https://www.mentalhealth.org.uk/a-to-z/t/talking-therapies>

⁴⁷ Memorandum of Understanding on Conversion Therapy The first version was in 2014.

⁴⁸ <https://www.psychotherapy.org.uk/about-ukcp/public-policy/conversion-therapy/>

⁴⁹ <https://www.psychotherapy.org.uk/wp-content/uploads/2018/07/UKCP-Memorandum-of-Understanding-2-on-Conversion-Therapy-in-the-UK.pdf>. Adult Psychiatric Morbidity Survey is a series of surveys of the mental health of people living in England. It is run every 7 years.

⁵⁰ (APMS) 2014 Chapter 12: Suicidal thoughts, suicide attempts and self-harm - Data Tables NHS Digital (Table 12.1 Prevalence and recency of lifetime suicidal thoughts, suicide attempts and self-harm, by age and sex 2014) Download Spreadsheets <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>

⁵¹ Life In Scotland For LGBT Young People. LGBT Youth Scotland 2018 <https://www.lgbtyouth.org.uk/media/1354/life-in-scotland-for-lgbt-young-people.pdf>

⁵² Stonewall 2017 SCHOOL REPORT The experiences of lesbian, gay, bi and trans young people in Britain’s schools in 2017 Josh Bradlow, Fay Bartram and April Guasp Stonewall, Dr Vasanti Jadv Centre for Family Research, University of Cambridge

⁵³ Life In Scotland For LGBT Young People. LGBT Youth Scotland 2018 <https://www.lgbtyouth.org.uk/media/1354/life-in-scotland-for-lgbt-young-people.pdf>

risk of poor mental health and low wellbeing. [41], [42], [53], [54], [55],[56] The following sentence seems out of place or unrelated to the point of the paragraph: Several studies in several countries show that for some, sexuality can change with or without therapeutic help. [47],[48] ,[57],[58],[59],[60][61],[62],[63]

9. **FSS Q31 (answered by 361 respondents) reports 13 people who said their attempt to change sexual orientation worked completely, and another 60 who said ‘It seemed to work for a while’.** Bisexuals were the second largest sexual minority in the FSS and yet they were ignored in the analysis of results. FSS fails to address the conflict between banning therapy to support LGB people’s heterosexual capacities, [46],[64] and the heterosexual relationships of bisexually attracted people⁶⁵ – despite public data showing that when bisexuals marry, it is almost always to the opposite sex²⁸
10. **That the majority (51.1%) of respondents to the FSS were in favour of criminalising therapy is a weak result for such a biased sample.** It was the youngest - who were the least likely to have experienced any therapy - who were the most likely to want it banned. This therefore is a prevailing point of view irrespective of experience. The FSS is demanding criminalisation and additional safeguarding, and implicitly seeks an end to religious ministry or even prayer in support of opposite sex marriage and attraction. Yet counter to the claims made, no harm was been demonstrated to be happening now. The FSS demands are not supported by its data as presented. It would be a seriously retrograde step if science were to be decided by majority vote.

We request FIFTH that the Report for Submission to the 44th Session of the Human Rights Council highlight the danger of excluding those formerly LGBT from the research data by excluding this group from contributing to surveys designed to have policy implications for entire population groups (and not limited to those identifying as LGBT only). As the foregoing analyses indicate, both the Government’s LGBT Survey Report and the Ozanne Foundation deliberately excluded participation from formerly identified LGBT – thereby eliminating any indicators of persons who had benefitted from therapeutic (or pastoral) interventions.

Question 5.

Has there been an identification of risks associated with practices of so-called “conversion therapy”?

⁵³ Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.

⁵⁴ ONS Digital 5 July 2017 People, Population and Community ‘Lesbian, gay, and bisexual people say they experience a lower quality of life’ <https://visual.ons.gov.uk/category/people-population-andcommunity/>

⁵⁵ Semlyen et al. Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys BMC Psychiatry (2016) 16:67 DOI 10.1186/s12888-016-0767-z

⁵⁶ Everett B. Sexual Orientation Identity Change and Depressive Symptoms: A Longitudinal Analysis. J Health Soc Behav. 2015; 56:37–58.

⁵⁷ Royal College of Psychiatrists' statement on sexual orientation Position Statement PS02/2014 April 2014

⁵⁸ Grossman L. interviewing Lisa Diamond: Sexuality is fluid – it's time to get past 'born this way' New Scientist 22 July 2015 <https://www.newscientist.com/article/mg22730310-100-sexuality-is-fluid-its-time-to-get-past-born-this-way/>

⁵⁹ Diamond LM and Rosky CJ, Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities, J. Sex Res. 2016 May-Jun;53 (4-5):363-91 DOI:10.1080/00224499.2016.1139665

<https://www.semanticscholar.org/paper/Scrutinizing-Immutability%3A-Research-on-Sexual-and-Diamond-Rosky/7a49cfc89f2a5e0bc60fc28e287b109890161b28>

⁶⁰ Geary RS, Tanton C, Erens B, Clifton S, Prah P, Wellings K, et al. (2018) Sexual identity, attraction and behaviour in Britain: The implications of using different dimensions of sexual orientation to estimate the size of sexual minority populations and inform public health

⁶¹ Ruth Lewis, Ph.D., Clare Tanton, Ph.D., Catherine H. Mercer, Ph.D., Kirstin R. Mitchell, Ph.D., Melissa Palmer, Ph.D., Wendy Macdowall, M.Sc., and Kaye Wellings, F.Ac.S.S. 2017 Heterosexual Practices Among Young People in Britain: Evidence From Three National Surveys of Sexual Attitudes and Lifestyles (See Table 2 especially)

⁶² Natsal The National Survey of Sexual Attitudes and Lifestyles Natsals 1&2 Reference Tables 4.3, 4.4. <http://www.natsal.ac.uk/natsals-12/results-archived-data.aspx>

⁶³ The Cut Nov 24, 2017 More Men Than You Think Identify As ‘Mostly Straight’ By Ritch Savin-Williams <https://www.thecut.com/2017/11/a-sex-researcher-explains-mostly-straight-men.html>

⁶⁴ Core Issues Trust Talking Therapy Poll (2014) https://www.comresglobal.com/wp-content/themes/comres/poll/Core_Issues_Trust_Therapy_Poll_April_2014.pdf

There remains no peer-reviewed scientific research that shows categorically, and on average, that therapeutic interventions for unwanted same-sex attractions are harmful. Despite this, the view persists that suicide (completion) is higher among the LGB community and very rarely is suicidal ideation (which is higher) examined in any context other than “internalized systemic homophobia” or “ego-dystonic homophobia”. Somewhat counterintuitively, most studies have found completed suicides *not* to be higher among LGBT people (with the exception of two very small groups – people who undergo transgender surgery and men in same-sex ‘marriages’ in Denmark – one of the most sexually liberal countries in the world). In the words of researcher RM Mathy,[66] ‘... studies of sexual orientation and attempted v. completed suicide have yielded different results. Nearly all studies of sexual orientation and attempted suicide have found that gay men and lesbians have higher rates of self-harm than heterosexuals. Conversely, all studies of sexual orientation and completed suicide have concluded that gay men and lesbians do not die by suicide at a higher rate than heterosexuals.’

Given that no resources are being allocated to understanding formerly identified LGBT persons, their needs and aspirations and how therapy restrictions are likely to impact on these individuals, it seems essential to review research that purports to show categorically that therapeutic interventions using change-allowing therapies are harmful

Serious harmful implications of therapy ban bills and research findings on suicide.

1. **The most recent Ryan study,⁶⁷ which has been used to claim change allowing therapy is harmful and contributes to suicide, was conducted by an LGBT advocacy organization and had the following serious flaws:**

- This small study near San Francisco, purporting to show harm from “conversion therapy,” looked at only parent-initiated efforts, by surveying adults who currently frequent LGBT bars and agencies, and asked about their adolescent experiences with regard to “conversion therapy.” **By research design, the study excluded any youth who may have changed through therapy since they recruited study subjects only from LGBT- supportive venues. The survey did not study client-initiated therapy at all. It has nothing to say about it.**
- **There was no control group, and the study relied on self-reports** of adults in the LGBT community who may have had a political interest in portraying change allowing therapy as harmful.
- **The definition for what constituted “conversion therapy” was vague**, nor was it clear if any such therapy was conducted by a licensed therapist using non-abusive, non-aversive, non-coercive, contemporary evidence-based methods and well-established practices.
- **The report identified parents and clergy as the most egregious violators of “conversion therapy,”** because they promote various religious values in regard to sexual behavior and gender identity.
- **Research does not support the view that traditional faiths cause mental health disparities for people who identify as LGBTQ.** Findings show those who follow their traditional faiths that reject same-sex relationships are no less happy, mentally healthy, satisfied with life, and flourishing than those of faiths

⁶⁶ The British Journal of Psychiatry Mar 2004, 184 (4) 361-362; DOI: 10.1192/bjp.184.4.361-a

⁶⁷ 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.

that accept same-sex relationships or those of no faith [68], [69], [70], [71], [72]

2. **Many potential risk factors for LGBTQ youth suicide, apart from therapy, have been identified, including depression, sexual promiscuity, alcohol and drug use, and more.** For example, the Youth Risk Behavior Surveillance⁷³ found that LGBTQ youth not only had the highest rates of suicide attempts or thoughts, but they also experienced higher rates of behaviors that are associated with higher suicide rates as follows:

- prevalence of current alcohol, marijuana, cocaine, heroine, or meth use
- sexual intercourse before age 13
- sexual intercourse with four or more persons
- forced to have sexual intercourse
- experienced sexual dating violence

Since suicide risk factors have been found to be much higher for LGBTQ-identifying youth *irrespective of therapy*, one cannot simply presume therapy is to blame.

3. In addition, the largest gene study reported, “We found several personality traits (loneliness and openness to experience), risky behaviors (smoking and cannabis use) and mental health disorders, but not physical traits, to be significantly genetically correlated with same-sex sexual behavior. **We found in both sexes that same-sex sexual behavior was positively genetically correlated with several psychiatric or mental health traits,**” for example, depression and schizophrenia in females and males and bipolar disorder in females.⁷⁴ (bold added)
4. Some clients report their depression⁷⁵ or suicidal thoughts⁷⁶ actually subsided or diminished because of the change-allowing therapy they received.
5. While about 18 out of the 50 states in the U.S. have legislated “conversion therapy” bans over the past seven years, and about as many states have rejected these bans or allowed them to die, **there is no evidence whatsoever that the rate of teen suicide in states that have bans has been impacted in any positive way.**

Science Regarding Change-allowing Therapy

6. **The APA task force on therapy (2009) concluded no research meeting scientific standards shows contemporary change-allowing therapy is harmful or ineffective for adults or minors.** It said scientific research reports that some adults changed same-sex

⁶⁸ Haynes, L. (Sept. 16, 2019). Are Religious Californians Really Harming the Mental Health of People Who Identify as LGBTQ? <https://www.thepublicdiscourse.com/author/laura-haynes/>

⁶⁹ Barringer, M., Gay, D. (2017). Happily religious: The surprising sources of happiness among lesbian, gay, bisexual, and transgender adults, *Sociological Inquiry*, 87, 75–96, DOI:10.1111/soin.12154

⁷⁰ Stephen C. (2017). The LGB Mormon Paradox: Mental, Physical, and Self-Rated Health Among Mormon and Non-Mormon LGB Individuals in the Utah Behavioral Risk Factor Surveillance System, *Journal of Homosexuality*, 64:6, 731-744, DOI: 10.1080/00918369.2016.1236570

⁷¹ Lefevor, G., Sorrell, S., Kappers, G., Plunk, A., Schow, R., Rosik, C., & Beckstead, A. (2019). Same-Sex Attracted, Not LGBQ: The Associations of Sexual Identity Labeling on Religiousness, Sexuality, and Health Among Mormons, *Journal of Homosexuality*, DOI: 10.1080/00918369.2018.1564006

⁷² 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*, <http://www.tandfonline.com/action/showCitFormats?doi=10.1080/0092623X.2018.1531333>

⁷³ U. S. Department of Health and Human Services, Centers for Disease Control and Prevention (2017). Youth Risk Behavior Surveillance—United States, 2017, *Morbidity & Mortality Weekly Report*, June 15, 2018, Surveillance Summaries, 67(8).

⁷⁴ Ganna, A., et al. (2019). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior, *Science*, 365, 882, p. 4-5. DOI: 10.1126/science.aat769

⁷⁵ Nicolosi J., Byrd, A., Potts, R. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86:1071-1088.

⁷⁶ Karten, E.Y., & Wade, J.C. (2010). Sexual Orientation Change Efforts in Men: A Client Perspective. *Journal of Men’s Studies*, 18(1), 84-102. DOI: 10.3149/jms.1801.84

attraction and behavior through therapy and some adults felt harmed. However, it used the latter as anecdotal, not scientific, evidence and based its recommendations on that.⁷⁷ It cited no research (because none exists) showing affirmative therapy is better. It also did *not* declare change allowing therapy unethical.

7. **A U.S. federal judge’s decision noted the many ways that expert witnesses opposing "conversion therapy" admitted** that there is no research on therapy with minors for unwanted same-sex attraction or behavior or for gender nonconforming identity that meets scientific standards.⁷⁸ **There is no more recent research that changes this status.**
8. **Aversive/behavioristic methods have not been used by therapists in 40-50 years.** This is the admission of the APA’s task force report (2009)⁷⁹ and of Utah law professor, Clifford Rosky (2019) who has drafted therapy bans in the U.S.⁸⁰

Research Findings on Sexual Orientation.

9. Experts on both sides largely agree that same-sex attraction and behavior and discordant childhood gender identity and expression are traits that likely develop from a mixture of genetic and environmental influences, but mostly from an individual’s experiences in their psychological, social, cultural, and possibly biological environment, and that these traits may shift or change through life experience—like other complex human traits, behaviors, or unwanted tendencies, psychotherapists help people diminish or change every day, using evidence-based methods and well-established practices therapists use around the world.

There is no reason that therapy that is open to change in unwanted sexual or gender feelings or behaviors should be any more dangerous or less effective than therapy to change other unwanted traits.

The definitive and largest gene study found:

“Behavioral traits, like sexual behavior and orientation, are only partially genetic in nature....they are also shaped in large part by a person’s environment and life experiences...Our genetic findings in no way preclude the additional influences of culture, society, family, or individual experiences, or of non-genetic biological influences, in the development of sexual behavior and orientation.”⁸¹ (bold added)

10. **LGB adolescents ^{82 83} and adults, ^{84 85 86} commonly experience shifts or changes in their sexual orientation through life experience, and these shifts are mostly toward or**

⁷⁷ APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Washington, DC: American Psychological Association, No causal evidence of harm: 42, 82-91. Reported change or harm: 49, 85. No studies reporting harm met task force scientific standards.

⁷⁸ Federal judge’s decision: <http://lc.org/PDFs/Attachments2PRsLAS/100419TampaOrderGrant-ingMSJ.pdf>, p. 32.

⁷⁹ APA Task Force Report (2009). 40-50 yrs—since about the 1960’s or 1970’s: pp. 22, 82.

⁸⁰ Professor Clifford Rosky (March 1, 2019). testimony on “conversion therapy” bill at House Judiciary Committee hearing, Salt Lake City, Utah. He said, “One of the amendments would exclude talk therapy and it, and focus only on what they call aversive practices like electric shock therapy. Licensed therapists haven’t been doing electric shock therapy and aversive practices for decades. Nobody’s doing that anymore.”

⁸¹ 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/>

⁸² Ott, et al. (2011).

⁸³ 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.

⁸⁴ 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

⁸⁵ Savin-Williams, Joyner, & Rieger (2012). 41: abstract, p.106.

⁸⁶ Dickson, N., Paul, C., & Herbison, P. (2003). Same-sex attraction in a birth cohort: Prevalence and persistence in early adulthood. Social Science and Medicine, 56, 1607–1615. doi:10.1016/S0277-9536(02)00161-2

to heterosexual. Therapy is a life experience.

11. **A 2009 APA task force report recommending LGBT affirming therapy and discouraging any kind of change-allowing therapy, claimed its recommendations were based on what the task force characterized as "key" scientific facts, including findings that (1) sexual orientation does not change through life events, and (2) same-sex orientation is not caused by trauma or family dysfunction.⁸⁷ But the task force failed to mention that the studies it relied on did not meet the APA task force's own scientific standards.⁸⁸ If those presumed scientific facts were true, then facilitating sexual orientation change through therapy would be impossible, and attempts to do so would only fail and potentially harm people and shame them when they failed to change. In fact, that is the exact claim being made by activist groups pushing for a therapy ban now.**
12. **However, five years after the APA's task force report made these claims to discourage any change allowing therapy, the *APA Handbook of Sexuality and Psychology* (2014), which the APA declared "authoritative,"⁸⁹ contradicted these claims wherein it actually recognized:**

- **Sexual attraction, romantic partnerships, behavior, and identity all commonly change for adolescents and adults.** "...research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time." "Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation." "Over the course of life, individuals experience the following: (a) changes or fluctuations in sexual attractions, behaviors, and romantic partnerships...."⁹⁰
- **Childhood sexual abuse has "associative and potentially causal links" to having same-sex partners for some,** based on research that includes a 30 year study of documented cases of childhood sexual abuse.⁹¹
- **Family experiences are causal factors in sexual orientation. This admission and research leave open the possibility that family dysfunction is a causal factor.⁹²**

94 95

The *APA Handbook* affirmed, "Psychoanalytic contingencies are evident as

⁸⁷ APA Task Force Report (2009). p. 86.

⁸⁸ Rosik, C. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* apply its research standards consistently? A preliminary examination. *Journal of Human Sexuality*, 4:70-85. <http://media.wix.com/ugd/>

⁸⁹ APA Handbook, 1:xvi.

⁹⁰ APA Handbook, 1:636, 562, 619.

⁹¹ APA Handbook, 1:609-610

⁹² 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

⁹³ APA Handbook, 1

⁹⁵ 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.
, L., Beauvais, 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," *Archives of Sexual Behavior*, 36:864-867.
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>

main effects or in interaction with biological factors.”⁹⁶

13. **These findings are more consistent with what some of our clients have claimed**, that they feel their same-sex attraction or behavior was forced on them by childhood sexual abuse or other trauma. Significantly, if these *APA Handbook* corrections of the APA task force’s scientific facts are accurate (and the science points toward their being true and shows they cannot be ruled out) then therapy to help people with unwanted same-sex attraction is warranted.
14. **Evidence-based, voluntary psychotherapy treats underlying psychodynamic and trauma factors that clients feel led to their same-sex attraction or behavior. Change may result as a by-product.** This therapy should not be banned. Minors should not be shamed for their reasonable request to have this therapy. Is it more compassionate to offer treatment that is open to a client’s desire for this change, or to affirm unwanted feelings or behaviors forced on victims by childhood trauma and just teach coping methods?
15. **One of the most comprehensive reviews ever conducted on over a century of change-allowing therapy research**, provides evidence that some people changed their sexual attraction and behavior when accompanied by professional therapy assistance.^{97 98}
16. **There are professional organizations around the world that support this therapy** that may lead to these changes.⁹⁹ Claims to the contrary notwithstanding, there is not a

⁹⁶ 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 reveal 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. However, gender nonconformity was not the only explanation for adverse experiences (p. 7).

⁹⁷ **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/EF18104.pdf> Read the Abbreviated Version (Issue Brief Report Summary): <https://downloads.frc.org/EF/EF18105.pdf>

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>

⁹⁸ 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, FreeToLoveMovie.com, voicesofthesilenced.com

⁹⁹ 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:

International Federation for Therapeutic and Counseling Choice (<https://iftcc.org/standards/>),

International Federation of Catholic Medical Associations (FIAMC) — has 65 member orgs around the world,

International Network of Orthodox (Jewish) Mental Health Professionals,

4 Organization Joint Statement—American College of Pediatricians, American Association of Physicians and Surgeons, Christian Medical and Dental Association, and Catholic Medical Association—Support Minors’ Right to Therapy (5-25-2017), (<https://www.acpeds.org/wordpress/wp-content/uploads/5.25.17-Joint-Therapy-letter-with-signatures.pdf>),

professional consensus in opposition to such therapy.

Findings on Gender Identity

17. **The APA Handbook of Sexuality and Psychology (2014) and many other professional organizations agree discordant gender identity also develops from a complex mixture of biological and environmental influences.**¹⁰⁰
18. **Many professional organizations also agree that childhood gender dysphoria overwhelmingly resolves naturally by late adolescence or adulthood if not affirmed.**¹⁰¹ Even the *APA Handbook* and the “Guideline” of the Endocrine Society and its 6 co-sponsoring professional organizations caution that affirming a child’s discordant gender identity may stop natural resolution.¹⁰²
19. **The APA Handbook and the “Standards of Care” of the World Professional Association for Transgender Health (WPATH) admit, and robust research strongly suggests, pathological influences may lead to discordant gender identity.**
 - Standards of Care (2011) by WPATH found that **gender dysphoria may be “secondary to and better accounted for by other psychiatric diagnoses.”** A rigorous 8 year study has found that about **two-thirds of adolescents experienced a number of other psychiatric disorders, and hospitalizations for disorders, during the 6 months leading up to** first evidence of gender nonconformity, at far higher rates than gender concordant peers.¹⁰³
 - The *APA Handbook* cautions, an affirmative approach “aims to assist the environment (family, school, community) in **fully accepting the gender-variant identity of the child....This approach runs the risk of neglecting individual problems the child might be experiencing** and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist...¹⁰⁴

American Association of Physicians and Surgeons (<https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/>),

American College of Pediatricians (<https://drive.google.com/file/d/0B9njBaZTrCfSZ09tRDEQaVVFEN1hqVnpHb3I5RTlqcTI5bHIB/view>),

Christian Medical and Dental Association (see joint statement),

Catholic Medical Association (<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/>),

Association of Christians in Health and Human Services.

¹⁰⁰ Hembree, W., et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*,102:1–35, <https://aca-demio.oup.com/jcem> , p. 6-7.

Six co-sponsoring Associations with the Endocrine Society: Amer. Assn. of Clinical Endocrinologists, Amer. Soc. of Andrology, Eur. Soc. for Pediatric Endocrinology, Eur. Soc. of Endocrinology, Pediatric Endocrine Soc., and World Prof. Assn. for Transgender Health.

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.

¹⁰¹ Hembree, et al., (2017), p.11. DSM-5, p. 455. *APA Handbook*, 1:744.

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>)

¹⁰² *APA Handbook* (2014), 1:750. Hembree, et al. (2017), p. 11.

¹⁰³ Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers.

Pediatrics. 2018;141(5):e20173845

¹⁰⁴ *APA Handbook of Sexuality*, 1: 743-744, 750.

- While research into all approaches to treating gender dysphoria is in a primitive stage, it may be reasonable to expect that treating pathological influences that lead to a discordant gender identity may resolve it. It would certainly be premature to rule out that possibility or to legislate against it.

20. **Anecdotal testimonies of trans-regretters indicate some who sought help for discordant gender identity tragically received affirmative “transition” support that led to body harm instead of psychotherapy.** We urge human rights legislators never to accept banning psychotherapy that would help someone resolve gender distress or come to embrace their innate body sex.
21. **Failure to treat underlying trauma may lead to ongoing trauma, mental health problems,¹⁰⁵ and suicide.¹⁰⁶** Affirming sexual or gender feelings or behaviors caused by trauma is harmful and neglects evaluating for underlying causes. Yet the proposed ban allows only for “transition” support from therapists.
22. **Therapy that affirms the rejection of one’s own body is a path that often leads to a protocol of experimental¹⁰⁷ puberty-blockers,¹⁰⁸ risky,¹⁰⁹ high dose, toxic,¹¹⁰ cross-sex hormones, permanent infertility, potential loss of sexual function, medical dependency for**
112
 life, healthy breasts removal, potential surgical destruction of reproductive organs,¹¹¹ leading to a 2-2.5 times higher rate of deaths from heart disease and cancers, a persisting 2.8 times higher rate of psychiatric hospitalizations, and a 19 times higher rate of *completed* suicides—even in an affirming society.¹¹³ A U.S. government research review said these statistics are from the best available research.¹¹⁴ **These are astonishing treatment costs and outcomes.**
23. **For these reasons, an increasing number of medical organizations oppose these controversial procedures.¹¹⁵** Treating gender dysphoria with evidence-based trauma

¹⁰⁵ APA Handbook, 1: 744, 750.

¹⁰⁶ Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003). Psychological autopsy studies of suicide: a systematic review, *Psychological Medicine*, 33: Abstrace, p. 402, Cambridge University Press, DOI: 10.1017/S0033291702006943

Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslavsky, A., and Kessler, R. (2013). Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A), *JAMA Psychiatry*, 70(3): p. 18, Table 3, doi:10.1001/2013.jamapsychiatry.55.

¹⁰⁷ There is no research. This study one will be only for 5 years, not long enough to give long term/endpoint outcomes.

Olson, J., Garofalo, R., Rosenthal, St., Spack, N. (2015-2010). The Impact of Early Medical Treatment in Transgender Youth. National Institutes of Health. (Grant study description.) <http://grantome.com/grant/NIH/R01-HD082554-01A1>

¹⁰⁸ Gagliano-Juca, T., Traveison, T., Kantoff, P. Nguyen, P. L., Taplin, M-E, Kibel, A., Huang, G., Bearup, R., Schram, H., Manley, R., Beleva, Y., Edwards, R., Basaria, S. (2018). Androgen Deprivation Therapy is Associated with Prolongation of QTc Interval in Men With Prostate Cancer. *Journal of the Endocrine Society*, 2: 485-496.

Hembree, et al. (2017), pp. 14-15.

Laidlaw, M., Van Meter, Q., Hruz, P., Van Mol, A., & Malone, W. (2019). Letter to the editor: “Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society clinical practice guideline,” *Endocrine Society*.

¹⁰⁹ WPATH Standards of Care (2011), p. 24.

Hembree, et al., (2017): See ratings (indicated by a row of circles).

¹¹⁰ WPATH, Standards of Care (2011), pp. 37-40, 50, 97-104.

Hembree et al. (2017), pp. 21-25.

Laidlaw, M. (Oct. 24, 2018). The gender identity phantom, <http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/> Endocrinologist, expert witness to CA legislators.

¹¹¹ Hembree, et al, (2017).

¹¹² WPATH Standards of Care (2011).

¹¹³ Dhejne C, Lichtenstein P, Boman M, Johansson ALV, La gstro 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.

¹¹⁴ 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-cover-age-database/details/nca-decision-memo.aspx?NCAId=282>.

¹¹⁵ Multiple medical groups throughout the world, including the *Royal College of General Practitioners*, the *Swedish Pediatric Society* and the *Royal Australian College of Physicians* have warned against these "gender affirmative" interventions.

See also: gdworkinggroup.org
YouthTransCriticalProfessionals.org

treatments or well-established practices is safer and therefore should not be banned.

We request SIXTH that the Report to be submitted to the 44th Human Rights Council urges legislators not to oppose ethical contemporary therapy that is open to clients' goals of change for sexual attraction or behavior or for gender identity or expression they do not want. No one should take away their freedom and their right to develop attractions consistent with their faith, to identify as they choose, to live the life that brings them joy—and to have support to do so. The Human Rights Council is asked to consider what risk assessments they have encouraged States to make with respect to those who formerly identified as LGBT and no longer do so.

Question 6.

Is there a State position on what safeguards are needed, and what safeguards are in place to protect the human rights of individuals in relation to practices of so-called “conversion therapy”? This question includes the following:

- a. Safeguards to protect individuals from being subjected to “conversion therapies”.**
- b. Broader statutory rules or administrative policies to ensure accountability of health care and other providers.**

By banning therapeutic choice - rather than regulating it - and by elevating a single monoculture that excludes any ideological diversity, it is probable that any critical debate is stifled and academic research that challenges policy is unlikely. The short-sightedness of this approach can only lead to the rise of informal and unregulated practices by unregulated, “underground” practitioners. Far from providing protection to individuals being exposed to poor or unethical practices, the current strategy of banning therapeutic choice will, in our view, lead to greater harm.

The refusal of any professional group to engage with the scientific arguments and academic research of any other professional group is a dangerous precedent.

Specifically, it is likely that states supporting bans will now force those who are bisexual and who wish to maximise one or the other trajectory in their lives are now to be forced into gay-affirming therapies only. How can this possibly be fair or without risk?

We request SEVEN that the Report to be submitted to the 44th Human Rights Council urges legislators to understand that banning therapeutic choice in the name of “Conversion Therapy” will actively damage individuals who are bi-sexual who wish to maximise their heterosexual potential. Banning as opposed to regulation strategically may well bring direct harm to individuals who will now distance themselves from the professional mental health providers they would otherwise trust. Making use of unregulated providers will be high risk but considered necessary because of the loss of confidence in professionals. This will be a direct consequence of the current failure to engage with those who will not support such an approach.

There will be many more direct and serious harmful consequences of banning much needed therapy as follows:

A therapy ban will deprive some individuals who have LGBTQ experiences of much needed therapy. The *APA Handbook of Sexuality and Psychology*, which the American Psychological

Association declared authoritative,¹¹⁶ **and research, say family factors^{117 118 119} and childhood sexual abuse^{120 121} may be causal factors** in having same-sex partners for some, and family pathology^{122 123} may be a causal factor for transgender identity. **Affirmative therapy** requires affirming LGBTQ feelings or behaviors caused by trauma. It denies harmful underlying causes for some. Treating underlying causes may shift/change LGBTQ feelings. Failure to treat^{124 125} can lead to mental health disorders and suicide .^{126 127} Contemporary, ethical^{128 129} therapists who are open to change use evidence based trauma interventions and well established practices used by therapists worldwide. There is no reason why this therapy should be more harmful or less effective than any other therapy. Some clients report their depression¹³⁰ or suicidality¹³¹ subsides from this therapy. A therapy ban will deprive patients of much needed therapy.

Under a ban that includes adults, there will be marriages and families that cannot be saved. For minors, those who aspire to opposite-sex marriage also will be deprived of their right to love who they want and live as they desire and to have help to do so.

If a middle-aged, 40 year old mother of 3 says to a therapist, “I love my husband and children, but recently I have felt attracted to someone else. Please help me *decrease my attraction* to the other person,” and if the other person is a man, a therapist can help her. But, if the other person is a woman, a therapy ban requires the therapist to refuse or be opened to punishment. The therapist might not even be allowed to help with her change her *behavior* so she does not act on her unwanted attraction feelings.

- ¹¹⁶ 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>
- ¹¹⁷ Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics*, 141(5): e20173004. <http://pediatrics.aappublications.org/content/early/2018/04/12/peds>.
- ¹¹⁸ *APA Handbook*, 1:583
- ¹¹⁹ 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., Beauvais, 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,” *Archives of Sexual Behavior*, 36:864-867.
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>
- ¹²⁰ 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
- ¹²¹ *APA Handbook*, 1:609-610
- ¹²² *APA Handbook of Sexuality and Psychology* (2014), 1: 743-744, 750.
- ¹²³ Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics*, 141(5): e20173004. <http://pediatrics.aappublications.org/content/early/2018/04/12/peds>.
- ¹²⁴ *APA Handbook*, 1: 744, 750.
- ¹²⁵ Becerra-Culqui, et al. (2018).
- ¹²⁶ Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003), Psychological autopsy studies of suicide: a systematic review, *Psychological Medicine*, 33: 395–405, Cambridge University Press, DOI: 10.1017/S0033291702006943
Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslavsky, A., and Kessler, R. (2013), Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A), *JAMA Psychiatry*, 70(3): p. 18, Table 3, doi:10.1001/2013.jamapsychiatry.55.
- ¹²⁷ Dhejne (2011).
- ¹²⁸ Alliance Practice Guidelines Task Force (2017). Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy, Alliance for Therapeutic Choice and Scientific Integrity Task Force on Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy (SAFE-T), https://a20ceadd-0fb7-4982-bbe2-099c8bc1e2ae.filesusr.com/ugd/ec16e9_68b6f7dbe5bc4daab554c37ee9bcf29f.pdf
- ¹²⁹ International Federation for Therapeutic Choice and Scientific Integrity, Standards, <https://iftcc.org/standards/>
- ¹³⁰ Nicolosi J., Byrd, A., Potts, R. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86:1071-1088.
- ¹³¹ Karten, E.Y., & Wade, J.C. (2010). Sexual Orientation Change Efforts in Men: A Client Perspective. *Journal of Men’s Studies*, 18(1), 84-102. DOI: 10.3149/jms.1801.84

The Royal College of Psychiatrists erroneously implies cases of same-sex attracted individuals in opposite sex relationships are not common. It said, “Nevertheless, sexual orientation for most people seems to be set around a point that is largely heterosexual or homosexual.”¹³²

But the *APA Handbook of Sexuality and Psychology* acknowledges, and robust research establishes, **most people by far who experience same-sex attraction also experience opposite-sex attraction.**

133

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.”

The definitive document, Office of National Statistics, Sexual Orientation, UK (2017), found that about a quarter of bisexuals in the United Kingdom are married, mostly to the opposite sex.¹³⁴ Many both sex-attracted people are in opposite-sex relationships because they prefer to be. Some may want therapy to help them decrease their same-sex attraction or behavior so they can maintain the marriage they desire and the family they and their spouse procreated together.

1. Attraction to engage in some illegal sexual behaviors cannot be treated under a therapy ban. Illegal *behaviors*, such as sexual behavior with children, might be allowed be addressed under some therapy bans, but the *attraction* to engage in the those behaviors could be treated only if the behaviors are directed toward opposite-sex, not same-sex, victims. For example: a therapist could help a man change his sexual attraction if he desires 5 year old girls but not if he desires 5 year old boys. This is dangerous.

It is next to impossible for a therapist to completely separate therapy that could lead to a change in same-sex attraction feelings or confused identity feelings, from therapy for related behavior, as attractions or feelings and behaviors are inextricably linked.

A therapy ban may recognize therapy can change *illegal* same-sex *behavior* and allow it. So why not allow change for *everyone*? Sexual politics micromanages people’s sexual behavior. A government should not discriminate about which people can get help and what help they can get.

2. Therapists will be required to discriminate against clients based on sexual orientation. Many kinds of symptoms and recognized disorders - from unwanted emotional and sexual ties that a sexual abuse victim may experience toward an abuser, to desire to have sex with minors, to compulsive sexual thoughts, to pornography addiction or sexual addiction, and more - could be treated only if directed toward the opposite, not same, sex.¹³⁵

¹³² Royal College of Psychiatrists’ statement on sexual orientation, April 2014, p. 2.

¹³³ 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, L. & Rosky, C. (2016). Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research*, 00:7, Table 1. DOI: 10.1080/00224499.2016.1139665 ; and reviewed in Diamond, L. (2014) Chapter 20: Gender and same-sex sexuality. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches*. Washington D.C.: American Psychological Association. vol. 1, p. 638.

¹³⁴ Office of National Statistics (ONS): Sexual orientation, UK: 2017.

¹³⁵ Joseph Nicolosi, Jr., Ph.D. (Feb. 14, 2018). Expert testimony in Maine, audio and written, <http://www.therapyequality.org/testimony-dr-joseph-nicolosi-jr>.

Joseph Nicolosi, Jr., Ph.D. (April 3, 2018). Expert testimony in California in opposition to AB 2943, Privacy and Consumer Protection Committee. http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=5330.

3. **A ban empowers social pressure and bullying against questioning individuals.** Some gay men and lesbians come to experience opposite-sex attraction through life experience¹³⁶ or counseling,¹³⁷ ¹³⁸ but LGBT communities can exert strong, overt social pressure or bullying against change. Yet some change. Permanently depriving people of needed therapy is intense social pressure and bullying.

4. **The characterization of all change allowing therapy as harmful, stigmatizes and puts at risk ethical therapy** that uses mainstream therapy methods and has been demonstrated to be helpful and effective for many.¹³⁹ ¹⁴⁰ Opponents to “conversion therapy,” appear to equate all therapy that is open to a client’s goal of change with harmful “conversion” therapy utilizing aversive or coercive methods.

It is premature and harmful to dictate what therapies are effective or not, since there is widespread disagreement on such in the scientific literature. The scientific process, not legal fiat or activist lobbies in professional guilds, should be allowed to resolve scientific questions.

5. **Anecdotal testimonies of trans regretters indicate some who sought help for trauma they felt led to their discordant gender identity tragically received affirmative “transition” support that led to body harm instead of psychotherapy. We urge that a state never to accept banning psychotherapy that would help someone resolve gender distress or come to embrace their innate body sex.**

6. **Therapy that affirms the rejection of one’s own body leads to serious bodily destruction, deaths from diseases, and suicides, while psychiatric hospitalizations continue to persist long term at a 2.8 times higher rate than for the general population. These are astonishing treatment costs and outcomes. It is not transgender health, and it is hardly suicide prevention.** Resolving gender dysphoria by treating underlying trauma or psychiatric disorders

¹³⁶ Bullying for change through life experience.

Diamond, L. (2008). *Sexual Fluidity: Understanding Women’s Love and Desire*. Cambridge, Mass.: Harvard Press, pp. 114.

Diamond, L. & Rosky, C. (2016). Scrutinizing immutability: Research on sexual orientation and U.S. Legal Advocacy for sexual minorities. *Journal of Sex Research*, 00(00), 20.

REBUTTAL: Rosik, C. (2016). Research review: The quiet death of sexual orientation immutability; How science loses when politicaladvocacy wins. <http://www.learnlove.co.za/images/Quiet-Death-of-Sexual-Orientation-Immutability.pdf>

¹³⁷ **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>

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>

¹³⁸ 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, FreeToLoveMovie.com

¹³⁹ **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>

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>

¹⁴⁰ 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, FreeToLoveMovie.com

through psychotherapy is incomparably safer, yet bans allow only body harming options that have no guarantee of outcomes that justify it.

7. **Because of these harms, an increasing number of medical organizations oppose controversial medical gender procedures.**¹⁴¹ Treating gender dysphoria with evidence-based trauma interventions or well-established psychotherapy practices is safer and therefore should not be banned
8. **We represent the views of professional organizations and therapists around the world that support therapy that may lead to changes in sexual or gender feelings or behaviors.**¹⁴² Claims to the contrary notwithstanding, there is not a professional consensus in opposition to such therapy.
9. **Some who diminished or changed their sexual or gender feelings or behaviors regret the years they lost that they could have lived the way they do now, because their family and cultural pressure led them to believe they could not and should not try to change through therapy.**

We request EIGHT that the report to be submitted to the 44th Session of the Human Rights Council indicates clearly how it intends to ensure specifically that points 1-9 (above) concerning the grave consequences of banning therapeutic choice – commonly labelled “Conversion Therapy” will be managed. We believe that it is the responsibility of the Human Rights Council to distinguish between ethical and non ethical practices to ensure the survival of ethical work that recognizes the legitimacy of change-allowing therapies.

Question 7

Are there any State institutions, organizations or entities involved in the execution of practices of so-called conversion therapy? If so, what criteria have been followed to consider these as a form of valid State action?

In the context of the United Kingdom, professional engagement with the pros and cons of change-allowing therapies has been removed from investigative and inquiry work, except where it is gay-affirming. This is evidenced in the viewpoint discrimination that has resulted in therapists being removed because of ideological differences – and not because of professional violations. Training cannot be accessed unless the values of the mental health executives are upheld. This means that in

¹⁴¹ Multiple medical groups throughout the world, including the Royal College of General Practitioners, the Swedish Pediatric Society and the Royal Australian College of Physicians have warned against these "gender affirmative" interventions.

See also:

gdworkinggroup.org

YouthTransCriticalProfessionals.org

¹⁴² **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: International Federation for Therapeutic and Counseling Choice (<https://iffcc.org/standards/>),

International Federation of Catholic Medical Associations (FIAMC) — **has 65 member orgs around the world,**

International Network of Orthodox (Jewish) Mental Health Professionals,

4 Organization Joint Statement—American College of Pediatricians, American Association of Physicians and Surgeons, Christian Medical and Dental Association, and Catholic Medical Association—Support Minors' Right to Therapy (5-25-2017), (<https://www.acpeds.org/wordpress/wp-content/uploads/5.25.17-Joint-Therapy-letter-with-signatures.pdf>),

American Association of Physicians and Surgeons (<https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/>),

American College of Pediatricians (<https://drive.google.com/file/d/0B9njBaZTrCfSZ09tRDEQaVVEN1hqVnpHb3I5RTlqcTI5hHIB/view>),
Christian Medical and Dental Association (see joint statement),

Catholic Medical Association (<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_1d6108cfa05d4a73921e0d0292c0hc91.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/>),
Reintegrative Therapy Association (ReintegrativeTherapy.com)

Association of Christians in Health and Human Services.

fact a *de facto* ban has been in place since the introduction of the Memorandum of Understanding on Conversion Therapy – a document that is ideologically motivated but has almost no basis in scientific reality. This is hardly a way to develop social policy in a democratic society. Scientific method used to discern fact from ideology and belief is best achieved through robust debate across ideologically divided perspective. When only one ideology is allowed to become judge, jury and executioner it is unlikely that balance and equity will be the characters policy produced. It is difficult for us to imagine how a practice that is to become criminalized by one part of the population may become legitimate for another. What practice will be criminalized by one but become legitimate for another? This needs clarification before comment can be offered.

We Request that the Report for Submission to the 44th Session of the Human Rights Council explains why psychodynamic approaches for gender dysphoria or pedophilia in support of clients seeking change is NOT “Conversion Therapy”, but the same modalities applied to unwanted same-sex attraction IS “Conversion Therapy”.

Question 8

Have any State institutions taken a position in relation to practices of so-called “conversion therapy”, in particular:

- a. Entities or State branches in charge of public policy;
- b. Parliamentary bodies;
- c. The Judiciary;
- d. National Human Rights Institutions or other State institutions;
- e. Any other entities or organizations.

We offer the following Government Research review in the United States of America with specific reference to Centers for Medicare and Medicare Services, Health and Human Services in the USA.

In the United States, in 2016, the Centers for Medicare and Medicare Services (CMS) under Health and Human Services (HHS) during the Obama administration, undertook an original and comprehensive research review on gender reassignment surgery. It concluded that “there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes.” It found that all 33 studies it reviewed had “potential methodological flaws,” and that “[o]verall, the quality and strength of evidence were low.” In the best studies, patients “did not demonstrate clinically significant changes” after surgery.” In one of the very strongest studies, conducted in Sweden, post-surgical transgender patients had a suicide rate 19 times higher than that the general population. The CMS declined to issue a National Coverage Decision (NCD) that would mandate coverage for such surgery. ¹⁴³

Substance abuse and Mental Health Services Administration (SAMHSA) of Health and Human Services (HHS) of the United States

Some professional organizations posted an opinion statement on “conversion” therapy on the website of this agency (SAMHSA). It would be an error to interpret this report as being a government report. The statement explicitly bears this disclaimer:

“The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. Listings of any non-Federal resources

¹⁴³ Centers for Medicare & Medicaid Services, August 30, 2016, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282>, see especially pp. 24-27 for best study findings. For comment: Sprigg, P. (2018), Is Gender Reassignment Surgery “Medically Necessary?” <https://downloads.frc.org/EF/EF17L29.pdf>

are not all-inclusive and inclusion of a listing does not constitute endorsement by SAMHSA or HHS. (p. i)

Judicial Decisions in the United States

First `Judicial Ruling Example:

(*NIFLA v. Becerra*, 138 S.Ct. 2361, 2018.) In *NIFLA*, the Supreme Court expressly rejected the principle legal basis for the decision in *Pickup v. Brown*, in which the 9th Circuit said that SB 1172, which banned sexual orientation change efforts for minors, was constitutional. Justice Thomas, who wrote the main opinion, said (p. 14):

This Court has never recognized ‘professional speech’ as a separate category of speech subject to different rules. Speech is not unprotected merely because it is uttered by professionals.

As defined by the courts of appeals, the professional-speech doctrine would cover a wide array of individuals—doctors, lawyers, nurses, physical therapists, truck drivers, bartenders, barbers, and many others. See Smolla, *Professional Speech and the First Amendment*, 119 W. Va. L. Rev. 67, 68 (2016). One court of appeals has even applied it to fortune tellers. See *Moore-King*, 708 F. 3d, at 569. All that is required to make something a “profession,” according to these courts, is that it involves personalized services and requires a professional license from the State. But that gives the States unfettered power to reduce a group’s First Amendment rights by simply imposing a licensing requirement. States cannot choose the protection that speech receives under the First Amendment, as that would give them a powerful tool to impose “invidious discrimination of disfavored subjects.”

Second Judicial Ruling Example:

Change-allowing therapy also is not commercial speech, so it is protected speech under the U.S. Constitution. Matt Sharp, senior counsel of the constitutional law firm, Alliance Defending Freedom, gave this analysis of therapy bans when he wrote of a California bill, AB 2943, in personal communication with one of the authors of this comment:

The Supreme Court has made clear that commercial speech is “speech which does no more than propose a commercial transaction.” *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 762 (1976). Even when there is a commercial aspect to speech, that speech does not “retain[] its commercial character when it is inextricably intertwined with otherwise fully protected speech,” *Riley v. Nat’l Fed’n of the Blind of N.C., Inc.*, 487 U.S. 781, 796 (1988). When protected speech is part of the speaker’s message, this Court will “apply [its strict scrutiny] test for fully protected expression.” *Id.* Here, AB 2943 intrudes upon the purest sort of private, noncommercial, communications between a counselor and the client. It goes far beyond regulating speech that merely proposes a commercial transaction because it regulates what a counselor or therapist can and cannot say during a private session with a client. Thus, AB 2943 would be subject to strict scrutiny, which it is unlikely to survive.

Importantly, the same argument regarding commercial speech was made by California when defending the California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act in the case of *NIFLA v. Harris*. Even the 9th Circuit Court of Appeals rejected the argument that law was designed to regulate commercial speech, recognizing that it regulated the speech inside a pregnancy care center:

We find unpersuasive Appellees' argument that the Act regulates commercial speech subject to rational basis review. *See Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 651, 105 S.Ct. 2265, 85 L.Ed.2d 652 (1985). Commercial speech “does no more than propose a commercial transaction.” *Coyote Pub., Inc. v. Miller*, 598 F.3d 592, 604 (9th Cir. 2010) (citation omitted). The Act primarily regulates the speech that occurs within the clinic, and thus is not commercial speech.

Nat'l Inst. of Family & Life Advocates v. Harris, 839 F.3d 823, 835 n.5 (9th Cir. 2016), *rev'd and remanded sub nom. Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

Third Judicial Ruling Example:

Under a therapy ban, a therapist may provide affirmative therapy at the direction of the client, but a therapist is forbidden to provide change-allowing therapy at the direction of the client. Such non-neutral application of the law is not permissible under our Constitution. *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*, 138 S.Ct. 1719 (2018).

Alliance Defending Freedom (personal communication):

"How does the recent ruling in *Masterpiece Cakeshop* impact the constitutionality of AB 2943 (the consumer fraud therapy ban bill in California that the sponsor pulled on 8/31/2018)?"

The Supreme Court held that the state of Colorado did not act with the required neutrality towards Jack Phillips when it prosecuted him for declining to create a custom-designed wedding cake to celebrate a same-sex wedding. The lack of neutrality was evidenced by the state upholding the freedom of other cake artists to decline to create cakes that celebrate messages they found offensive.

AB 2943 operates in a similar manner. Counselors, religious organizations, and even churches are subjected to differential treatment when they provide fee-based services and resources to those seeking personal life changes based on their religious views. A counselor who, at the direction of a client, helps affirm the client's same-sex attractions remains free to do so. But a counselor who, also at the direction of a client, helps a client explore and pursue personal life changes for unwanted attractions is subject to liability. Such non-neutral application of the law is not permissible under our Constitution

Fourth Judicial Ruling Example

Regarding a city ordinance that banned “conversion therapy” in Tampa, Florida:

Federal Judge William F. Jung issued an [order](#) granting summary judgment to Liberty Counsel in its suit to invalidate the Tampa city ordinance that prohibited licensed counselors from providing voluntary talk therapy to minors seeking help to reduce or eliminate their unwanted same-sex attractions, behaviors, or identity. The ruling permanently strikes down the ordinance. The court ruled that local governments do not have authority to regulate counseling because it is the prerogative of the state.

The 41-page ruling states, in part:

Although the City expresses confident certitude, the City's experts, one or both, expressly agreed with the following points:

1. **Minors can be gender fluid and may change or revert gender identity.** Dkt. 192-2 at 38–40.
2. **Gender dysphoria during childhood does not inevitably continue into adulthood.** Dkt. 192-2 at 85–87.
3. Formal epidemiologic studies on gender dysphoria in children, adolescents, and adults are lacking. Dkt. 192-2 at 92.
4. **One Tampa expert testified there is not a consensus regarding the best practices with prepubertal gender nonconforming children.** Dkt. 192-2 at 120–21.
5. **A second Tampa expert testified consensus does not exist regarding best practices with prepubertal gender nonconforming children, but a trend toward a consensus exists.** Dkt. 192-1 at 159.
6. Emphasizing to parents the importance of allowing their child the **freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated.** Dkt. 192-2 at 123.
7. Federal decision against city therapy ban endnotes—concluded:
8. One cannot quantify or put a percentage on the increased risk from conversion therapy, as compared to other therapy. Dkts. 192-2 at 131; 192-1 at 198–99.
9. Scientific estimates of the efficacy of conversion therapy are essentially nonexistent because of the difficulties of obtaining samples following individuals after they exit therapy, defining success, and obtaining objective reassessment. Dkt. 192-1 at 136–37.
10. **Based on a comprehensive review of this work, the American Psychological Association 2009 SOCE Task Force concluded that no study to date has demonstrated adequate scientific rigor to provide a clear picture of the prevalence or frequency of either beneficial or harmful SOCE outcomes. More recent studies claiming benefits and/or harm have done little to ameliorate this concern.** Dkt. 192-1 at 148.
11. No known study to date [looking at 2014 article Dkt. 192-6 at 2] has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE. Dkt. 192-1 at 149.
12. No known study [looking at same 2014 article] has provided a comprehensive assessment of basic demographic information, psychosocial wellbeing, and religiosity, which would be required to understand the effectiveness, benefits and/or harm caused by SOCE. Dkt. 192-1 at 150.
13. Although research on adult populations has documented harmful effects of SOCE, no scientific research studies have examined SOCE among adolescents. Dkt. 192-1 at 153.
14. **With extraordinarily well-trained counseling “in a hypothetically perfect world” it may be an appropriate course of action for a counselor to aid a gender-dysphoric child who wants to return to biological gender of birth.** Dkt. 192-1 at 171–72.
15. **There is a lack of published research on efforts to change gender identity among childhood and adolescents.** Dkt. 192-1 at 177.
16. As of October 2015 no research demonstrating the harms of conversion therapy with gender minority youth has been published. Dkt. 192-1 at 180–81. In 2018 an article was published on youth but causal claims could not be made from that 2018 report. Dkt. 192-1 at 181.”¹⁴⁴

United States Office for Patents and Trademarks.

Reintegrative Therapy® and Reparative Therapy® have federally registered trademarks with the United States Office of Patents and Trademarks. They have certain federal protections. Care must be taken in making statements about them specifically for which there is no specific scientific evidence.

¹⁴⁴ Liberty Counsel press release: <https://www.lc.org/newsroom/details/100419-tampa-counseling-ban-struck-down>
 Judge’s decision: <http://lc.org/PDFs/Attachments2PRsLAS/100419TampaOrderGrantingMSI.pdf> , p. 32.

Conflating either one with “conversion therapy” or “sexual orientation change efforts” can result in an instant lawsuit for maximum damage.

We request NINE that the Response to the 44th Human Rights Council pay close attention to the various Judicial Rulings in the USA (for example) and to the established patents and trademarks that recognize modalities legitimately applied to persons with unwanted and same-sex attraction, or gender confusions.

Conclusion

Thank you for the opportunity to submit to your process of preparing a report for the 44th session of the Human Rights Council of the United Nations. In our view there are major difficulties in any proposal to outlaw so called “Conversion Therapy” and such a report will need to address the following, given

1. the failure to distinguish between poor therapeutic practice and the legitimate use of psychotherapeutic and counselling modalities to explore sexual attraction fluidity exploration in therapy (SAFE-T)
2. the clarity with which the Universal Human Rights Declaration in protecting against discrimination on the grounds of sex and on the grounds of “other status”; protecting the freedom of speech, freedom of expression and the right to receive and impart information, the right of freedom of assembly and of conscience and the right for privacy, family life, home and correspondence, the right to marry and the right freedom of religion
3. the international shutdown of dissent leading to open and free discourse in the media, and in professional mental health associations concerning the issue of therapeutic choice
4. the absence of actual research and data on those formerly identified as LGBT persons which might lead to an understanding of the needs and aspirations of this part of our populations
5. the need to understand the impact on the formerly identified LGBT persons given their systematic and deliberate exclusion from survey gathering research of several decades and the use of advocacy science to mask their existence
6. the principle of autonomy in the case of same-sex attracted persons seeking therapeutic and counselling help is being violated and
7. for even bi-sex persons only gay-affirming therapies are being promoted and pursuing enhancement of heterosexual potential is to be criminalized
8. Several Judicial rulings are appearing not supportive of banning therapeutic choice, overriding personal client autonomy and of denying the freedoms of expression, religious freedom and the freedoms of conscience

**Science and Research Committee,
International Federation for Therapeutic and Counselling Choice,
London, 21 December 2019**

