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International Foundation for Therapeutic and Counselling Choice Open Letter to the United States Department of Health and Human Services, Administration for Children and Families, Commenting on the Proposed Rule to Require Foster Children in the United States to Be Placed Only With Foster Parents Who Will Follow the Affirmative Path for Foster Children Who Have LGBTQ+ Experiences.

To: U. S. H. H. S. Administration for Children and Families
Re: Notice of Proposed Rule Making
RIN: Regulatory information Number (RIN) 0970-AD03,
Safe and Appropriate Foster Care Placement Requirements for Titles IV-E and IV-B
Position: Opposed
Date: November 27, 2023

Dear Representatives of the Administration for Children and Families,

I am Laura Haynes, Ph.D., psychologist, executive board member and U.S.A. Country Representative, writing on behalf of the International Foundation for Therapeutic and Counselling Choice (iftcc.org) that serves professionals in about 35 nations. Thank you for the opportunity to express our deep concerns about the proposed rule for “Safe and Appropriate Foster Care Placement Requirements.”

The proposed rule would require that LGBTQ+ identified children be locked into an affirmative path and never know alternate paths that are prioritized in other countries that have long histories in research and treatment of gender dysphoria. The head of one of Finland’s two centralized gender clinics, also a leading researcher on affirmative medical treatment for gender dysphoria, Dr. Kaltiala, is warning American clinicians that gender affirmation is dangerous. There is not a professional consensus in support of affirmation. In fact, health authorities in Europe and professional organizations are increasingly

moving away from it with regard to gender identity for good reasons. The proposed rule is not supported by the most rigorous research or professional consensus worldwide. It would be seriously harmful. Please consider the evidence.

I. FOSTER CHILDREN WHO EXPERIENCE GENDER DISCORDANCE WOULD BE SERIOUSLY HARMED

1. Gender discordant identity may not last.

> The health authorities of Sweden, Finland, and England say gender identity formation may be part of an evolving process in youth, and gender dysphoria may be part of the search for identity typical of the developmental stage of adolescence and may subside. They say youths are changing their minds and regretting transition. (SEGM, 2022; COHERE, 2020; Kaltiala et al., 2015; Cass, 2022)
>
> In children, gender dysphoria will resolve in the vast majority of cases (85% on average) if the child is not affirmed with the use of a name, pronouns, clothes, and hair style of a discordant gender identity. Eleven out of eleven studies have come to this same conclusion, and a challenge to the findings has been well rebutted. (Singh, Bradley, & Zucker, 2021; Steensma et al., 2010; Ristori & Steensma, 2016; Zucker, 2018).

2. Affirmation of discordant gender identity is dangerous.

> By contrast, the vast majority of children who are socially affirmed will go on to take puberty blockers (Olson et al., 2016). Once children take puberty blockers, the vast majority go on to take cross sex hormones (Brik et al, 2020; Carmichael et al., 2021; de Vries et al., 2011; Kuper et al., 2020). Puberty blockers followed by cross sex hormones arrest sex organs at pre-pubertal size and function for life. Sperm or ova/eggs will not mature. The child is permanently sterilized—will never be able to reproduce children, and capacity for sexual pleasure and orgasm is hindered. (CHLA, 2016, pp. 28, 32, 35; Coleman et al., 2022, pp. S102, S119, S167) Post-pubertal cross sex hormones and mastectomies also harm bodies. Yet young people may still experience change in gender

identity even after the destruction of their sexual health and may regret affirmation, but what is gone is gone.

The purpose in prescribing the affirmative path that may include intentional temporary or permanent destruction of sexual health is to improve mental health. Yet large, prospective, longitudinal, cohort or national registry population based studies that used objective measures (not self report or parent report) and comparison groups actually found that affirmation led to increase in use of psychiatric medications for mental health problems with no end in sight (Hisle-Gorman et al., 2021; Glintborg et al., 2023), and increase in mental health visits for suicidal thoughts and attempts. (Hisle-Gorman et al., 2021). Most studies that claim benefit from medical gender interventions have not taken the trajectory of psychiatric medication or psychotherapy use into account, and we now know from these rigorous studies that they must. The rate of young people subsequently discontinuing gender drugs was as high as 26% to 36% within the first 4 years (Roberts et al., 2022), but for many, their bodies had already been harmed.

Health authorities in Finland, the United Kingdom, Sweden, and Florida have conducted systematic research reviews and found the research supporting the affirmative approach is of very poor quality. (NICE, 2021a; 2020b; NBHW, 2022; Georgas, 2018; Ludvigsson et al., 2023; COHERE, 2020; Florida Medicaid, 2022; Florida Health Department, 2022) These government health authorities have greatly restricted, if not abandoned, the affirmative approach. The clinical epidemiologist credited with initiating and concept and term “evidence-based medicine” said, “The policies of the Europeans are much more aligned with the evidence than are the Americans.” (Holloway, 2022)

Several professional organizations have followed the lead of the European health authorities. Examples are the National Association of Practicing Psychiatrists, (Australia, 2022), Royal Australian and New Zealand College of Psychiatrists (2021), Italian Psychological Association (2023), and National Academy of Medicine (France, 2021).

By contrast, commonly-followed position statements, guidelines, or standards of care of professional organizations in America

committed to gender affirmation have admittedly based their recommendations on research of poor quality or no research, no systematic research review, and/or no research at all that tells them the long term outcomes of their body altering interventions. (Endocrine Society, Hembree et al., 2017, p. 27 and see GRADE ratings for all their recommendations; World Professional Association for Transgender Health, Coleman et al., 2022, pp. S46, S66; American Academy of Pediatrics, Sapsford & Armour, 2023).

Now, Dr. Kaltiala from Finland, one of the first physicians to run a clinic devoted to treating gender concerns, has published a clarion call specifically to the United States, “Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.” Dr. Kaltiala warned, “My country, and others, found there is no solid evidence supporting the medical transitioning of young people. Why aren’t American clinicians paying attention?”

The government health authorities moving away from the affirmative model are prioritizing psychotherapy to resolve gender dysphoria. *That* is what the HHS should now do as well, and *not* double down on affirmation.

3. Higher rates of mental health problems and adverse childhood experiences may be causal for gender discordance.

It is true that there are studies finding that discordant gender identified young people have higher rates of adverse childhood experiences such as parent mental illness, family dysfunction, witnessing domestic violence, physical, emotional, or sexual abuse, bullying for reasons other than gender, psychiatric disorders, neuropsychological disabilities, suicidality, and self-injuring behavior. We share concern about these findings. Most of these studies do not tell us the direction of causality, however, and it is incorrect simply to assume that gender discordance or minority stress is the cause. Some of the studies do tell us the direction of causality, and they have found internationally that these conditions pre-existed thoughts about gender in about 33% of children and 60% to 89% of adolescents, therefore may predispose to or be causal for gender discordant identity. (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Bechard et al., 2016; Kozlowska,

Chudleigh, 2021; Kozlowska, McClure, et al., 2021; Hisle-Gorman, et al., 2021; Baams, 2018; Thrower, 2022)

Affirming discordant gender identity in adolescents is very likely affirming a symptom of underlying conditions that need treatment. Worldwide, 90% of people who commit suicide have unresolved mental health problems. (Cavanagh et al., 2003). Treating underlying conditions for gender discordance may reasonably be expected to relieve both gender dysphoria and suicidality, and not evaluating for and treating underlying conditions may reasonably be expected to risk mental health and suicidality.

4. The elevated rates of psychiatric conditions and suicidality in gender discordant children and adolescents should be treated with psychiatric, not gender specific or affirming, interventions.

Gender discordance should be treated by psychotherapy and psychiatry rather than gender specific services according to NIH England (Cass, 2022). Specifically, gender dysphoria in adolescents should be treated by evaluating for and treating psychiatric conditions that may predispose a young person to gender dysphoria, according to the health authority Recommendation in Finland (COHERE, 2020); this is what contemporary therapy does that explores potential for resolution of gender dysphoria through therapy, and the proposed rule would prohibit it as "conversion therapy." Failure to explore and treat individual problems in gender dysphoric children risks medical negligence according to the American Psychological Association's *APA Handbook of Sexuality and Psychology* (Bockting, vol. 1, p. 750). Psychiatric treatment of psychiatric disorders, not gender specific treatments, are the path to resolving mental health problems and suicidality in foster children.

II. FOSTER CHILDREN WHO EXPERIENCE SAME SEX SEXUALITY WOULD BE SERIOUSLY HARMED

5. As is true for discordant gender identity, same sex attraction may not last.

Many, if not most, adolescents who experience same sex attraction, behavior, or questioning outgrow it by young adulthood

if allowed to (Savin-Williams & Ream, 2007, p. 389; Savin-Williams, Joyner, and Reiner, 2012; Katz-Wise & Hyde, 2014; Ott et al., 2011; Laumann et al., 1994, p. 296) Skeptics of the Savin-Williams & Ream, 2007 findings have been well rebutted. (Fish & Pasley, 2015; Fish & Russell, 2918; Kaestle, 2019; Katz-Wise, Calzo, & Pollitt, 2015; Li, Katz-Wise, & Calls, 2014)

The *APA Handbook of Sexuality and Psychology* says many people experience notable changes in same sex attraction, behavior, and orientation identity—all three, and this is true for both men and women and both adolescents and adults—throughout the lifespan. It says, "…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." Again, it says, "Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation." And again, it says, "Over the course of life, individuals experience the following: …changes or fluctuations sexual attractions, behaviors, and romantic partnerships…." (Diamond, p. 636, Rosario & Scrimshaw, p. 562; Mustanski et al., p. 619 in APA Handbook, 2014, vol. 1).

6. Affirmation may foreclose the natural trajectory of sexuality for many if not most adolescents.

The *APA Handbook of Sexuality and Psychology* says most same sex attracted people are both sex attracted. It says, "Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." (Diamond, 2014) Abundant rigorous research has found this pattern internationally. (Diamond, 2014, *APA Handbook, vol. 1*, p. 633).

Research in the U.S. and U.K. has abundantly documented that most same sex attracted people, and especially both sex attracted people, who are in a relationship are with the opposite sex (ONS,

2017, Figure 5; ONS, 2021, Table 5; Hu & Denier, 20223b; 2023a, Table A4; Herek et al., 2010, Table 8; Kaestle, 2019, Figure 3 and p. 819; Heslin & Alfier, 2022, Tables 3 and 4; Jones, 2022, pp. 5-6) where they may experience satisfaction that is real. (Lefevor et al., 2019; Yarhouse, Pawlowski & Tan, 2003))

Satisfying relationships with the opposite sex can lead to increase in opposite sex fantasies and decrease in same sex interest, while satisfying relationships with the same sex can lead to increase in same sex interest and decrease opposite sex interest. Whether LGB identified individuals socialize in LGB social networks or socialize in social environments where they have contact with many people the opposite sex who are opposite sex attracted impacts relationship opportunities which in turn may affect the trajectory of sexual attraction. (Diamond, 2008, pp. 114-118; Diamond, 2014 in *APA Handbook*; Diamond & Rosky, 2016, p. 8; Pomeroy, 1972, pp. 76-77) Affirmation steers young people toward LGBTQ+ specific social networks and is likely in itself to increase same sex attraction that otherwise would have naturally decreased through life experience for some.

Most both sex attracted people and some predominantly same sex attracted people feel they have some choice in their sexual orientation (Herek, 2010). Some choose an opposite sex relationship because they want to procreate children with their spouse, a natural desire and source of great joy for many. (Diamond, 2008, 114-118)

Coercing foster children into a predominantly LGB specific path and environment may lock children and adolescents long term into same sex sexuality who otherwise would have shifted toward or to heterosexual sexuality with fewer mental health problems and with procreative possibility with their spouse.

III. FOSTER CHILDREN WOULD BE DEPRIVED OF SUPPORT THAT DOES NOT CARRY THE HARMS OF AFFIRMATION

7. Children need parent support, but it does not have to be support for LGBTQ+ identity.

Studies that have said children do better with parent support of an LGBTQ+ affirmative kind do not include comparison groups for children who have supportive parents but not for LGBTQ+ identity. A rare study that did make this comparison found that “social support in general (from family and peers), but not necessarily in terms of affirming one’s child gender status, plays a role for the psychological outcomes.”(Sievert et al., 2021, p. 90)

8. The proposed rule takes a position that people of traditional faiths are dangerous for LGBTQ+ identified children and adolescents. Supporters of the proposed rule may not be aware of the following research.

A. People of traditional religious faith can create environments for children who have same sex attraction and gender discordance that are as safe if not safer than people trained in an affirmative path.

A bill introduced into the California state legislature in 2019 referenced a study to argue that LGBTQ affirmation was needed in school environments to reduce bullying, but the study actually found the opposite. I testified about this research before a legislative hearing committee. I also published about the actual findings, saying, (Haynes, 2019; re Kosciw et al., 2017)

> An ironic research example is the GLSEN 2017 School Environment Survey referenced in California AB-493 to support enforcing LGBTQ-affirmative practices for safe and welcoming schools.
>
> The survey found that religious schools did not have LGBTQ-affirming curriculum, clubs, website access, library resources, textbooks, teachers, administrators, or policies. From these findings, one might expect religious schools would be the most dangerous environment for sexual or gender minority students.
>
> However, the Survey actually found that religious schools ranked among the safest for LGBTQ students, with fewer anti-LGBTQ remarks among students than in public schools, and the least victimization and bullying of any schools—

lower than private non-religious schools that used all the LGBTQ-affirmative methods (see Appendix 2).

B. Religion is a source of mental health and happiness for many same sex attracted people.

Research conducted by an ideologically diverse research team of LGB identity affirming and change-exploring therapy affirming researchers has found that there are same sex attracted people who do not participate in LGB identity specific communities or take an LGB identity. They regard same sex attraction feelings as feelings they have, not who they are. They do not believe they were “born gay.” They are more conservatively religious, experience religion as a source of health, prioritize opposite sex relationships or sexual abstinence, find change-exploring therapy more helpful, and are no less happy, mentally healthy, satisfied with life, and flourishing than those who take an LGB identity. (Barringer & Gay, 2017; Cranney, 2017; Lefevor et al., 2019; Rosik et al, 2021; 2023)

IV. FOSTER CHILDREN WOULD BE DEPRIVED OF THERAPY OPTIONS TO THE SERIOUSLY HARMFUL AFFIRMATIVE PATH

9. Foster children would be deprived of therapy options.

The proposed rule takes a position that “conversion therapy” is harmful and should be prohibited. Regarding therapy that is open to a client-directed goal to manage, reduce, or change same sex behavior or attraction, there are no studies of children. I therefore direct you to the following research on adults.

Several randomized, controlled studies of LGB identity sensitive therapy, standard therapies, and lay led support have found that men who have sex with men have successfully decreased same sex partners in order to reduce HIV risk and maintained the change in follow up studies that were conducted for up to a year. Men who were fathers and men for whom same sex behavior was inconsistent with their values (measured as “homonegativity”) were especially successful. (Shoptaw et al., 2005; Shoptaw, et al., 2008; Reback & Shoptaw, 2014; Nyamathi et al., 2017)

Two prospective, longitudinal, quasi-experimental studies have found that men, most of whom were religious, increased opposite sex attraction/expression, decreased same sex attraction/expression, and improved psychological well-being through professional psychotherapy (Pela & Sutton, 2021) or religious support groups (Jones & Yarhouse, 2012). A cross sectional study of mostly religious men that had similar findings noted that 41% of the participants were married, most of these with children, on average 3 children each. The percent of them engaged in same sex behavior before therapy was 71% and plunged to 14% after therapy. (Sullins, Rosik, & Santero, 2021) What this change means to these men, their wives, and their children can hardly be expressed.

Even a partial change may help some live in an opposite sex relationship, as most both-sex attracted adults who are in a relationship do and most both-sex attracted adolescents who will be in a relationship will do, more easily and enjoyably. It is also the case that even a partial change can help some achieve their therapy goal to be abstinent in order to live consistently with their religion that should be respected.

Research that has claimed that therapy that is open to a goal of decrease or change in same sex attraction is harmful:

> (1) Has looked largely or solely at LGB identified people and has largely or entirely omitted ex-LGB identified who may have changed and the non-LGB-identified population. (Rosik, 2022)
>
> (2) Has not looked at how much suicidality existed before versus after counseling (usually mixing together professional and pastoral counseling), therefore cannot legitimately infer that counseling caused suicidality. (Sullins, 2022b)
>
> (3) Has been relied on uncritically by those professional organizations that have taken a position that “sexual orientation change efforts” are harmful.
>
> (4) When research has compared suicidality before therapy to after therapy, it has found most of the suicidality occurred

before counseling, not after. Unsurprisingly, people who went to counseling were more suicidal than people who did not go to counseling, and the counseling did not increase suicidality and may even have decreased suicidality. (Sullins, 2022b; 2023a; 2023b; for a stress test in past 12 months only see Sullins, 2022a) The same is likely true for people who go to all counseling, including affirmative counseling.

(4) Many professional organizations around the world oppose banning the right to change-exploring therapy for undesired same sex sexuality or gender identity. (Haynes, 2021)

10. Foster children would be allowed access only to the affirmative path that, in effect, treats them as though gender discordance and same sex sexuality were biological traits and leads them to foreclose curiosity, self knowledge, or insight about the context that led to their sexuality or gender discordance.

Undergirding the proposed rule appears to be an unspoken viewpoint that the affirmation approach is affirming who a child is. In effect, the rule reifies discordant gender identity and same sex sexuality as who a person biologically is. This viewpoint has never been scientifically substantiated, and I know of virtually no professional organization that takes that view. Discordant gender identity and same sex sexuality are not simply biologically determined, inborn, who someone was born to be, or who someone biologically is.

A. Causes for gender discordance always include life experiences.

Around three quarters of gender identity discordant adolescents experienced psychiatric conditions before gender discordance. Adverse childhood experiences are known to increase psychiatric disorders. The likelihood is that adverse childhood experiences account for the development of psychiatric conditions and gender discordance.

Gender identity develops from a complex mixture of biological, psychological, social, and cultural influences. It is not simply biologically determined, inborn, or caused by having a brain of the opposite sex.

> Professional endocrine societies around the world published a global consensus statement saying there is no consistent evidence that the brains of gender incongruent people are different from the brains of gender congruent people. They said there is no biomarker for gender identity, that is, there is no biological thing that has been found that is gender identity that another person can find by looking at a person's brain or conducting a biological test. (Lee et al., 2016)
>
> The American Psychiatric Association's official diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* agrees. *(DSM-5-TR*, 2023, pp. 511, 517)
>
> I know of virtually no professional organization that takes the view that gender identity is simply biologically determined or inborn. A discordant gender identity is not "who someone biologically is."

B. As is the case for gender discordance, causes of same sex attraction or behavior always include psycho-social causes.

Regarding same sex sexuality, even the American Psychological Association's *APA Handbook of Sexuality and Psychology* (2014) says family (psychoanalytic) experiences and trauma may lead to same sex sexuality.

> "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects [stand alone causes] or in interaction with biological factors." (Rosario & Scrimshaw, 2014, in *APA Handbook, vol. 1,* p. 583)
>
> It also accepts that childhood sexual abuse has "potentially causal links" to having same sex partners for some people. (Mustanski, 2014, in *APA Handbook, vol. 1,* pp. 609-610)
>
> It further says, "The inconvenient reality….is that social behaviors are always jointly determined" by nature, nurture,

> and opportunity. (Kleinplatz & Diamond, 2014, in *APA Handbook, vol. 1*, p. 257)

As is the case with gender discordance,I know of virtually no professional organization that takes a view that same sex sexuality is simply biologically determined, inborn, or who someone was born be. The proposed rule does not affirm who foster children were born to be.

C. Life experiences are always involved in the development of gender discordance and same sex sexuality. These include adverse predisposing influences or causes. The affirmative path denies or ignores this.

D. The affirming path would foreclose foster children being curious about or having insight into these causes and the self-knowledge that could come from insight into themselves and their experiences.

E. Affirmative therapy may treat co-existing disorders or, in the case of gender discordance, may not treat them on the hazardous assumption that medical gender interventions will treat them. The affirmative path does not consider or treat links between adverse pre-disposing or causal psychiatric conditions and gender discordance or same sex sexuality. This medical neglect results in ongoing risk to mental health and suicidality. The proposed rule would require that foster children have access only to the affirmative path which is seriously harmful.

V. CONCLUSION

11. In conclusion, discordant gender identity and same sex sexuality may not last if they are not affirmed.

12. Sexual attraction feelings and a subjective sense of ones sex that are discordant to ones reproductive sexual role are not simply biologically determined or who someone was born to be. These feelings develop from a complex mixture of biological, psychological, social, and cultural influences. That is, they develop lifelong from life experiences that may include adverse life experiences that may need attention. This is all the more true for foster children who have experienced more

adverse life experiences than many people. Affirmation of LGBTQ+ identity, feelings, or expressions is not affirming who foster children were born to be, and it fails to look beneath the surface at potentially predisposing or causal adverse experiences or conditions to treat them and their links to LGBTQ+ identities and experiences. Affirmation is dangerous for foster children, because it may lead to intentional harm to their sexual health in the false hope of improving their mental health and forecloses therapy options that are alternative to the affirmative path.

13. Affirmation also may foreclose natural developmental paths for many to become comfortable in their skin or to experience greater sexual desire conducive to procreative fulfillment with a spouse.

14. Foster parents of traditional religions who care for foster children who experience same sex sexuality and gender discordance can provide an environment that is safe from bullying or victimization, provides psychological support, and does not foreclose natural developmental paths that flourish best when children are not directed down an affirmative path.

15. The proposed rule would have seriously harmful consequences. Therefore, we strongly recommend against adopting it.

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