INTERNATIONAL FOUNDATION FOR THERAPEUTIC & COUNSELLING CHOICE

Response ID [redacted]

Submitted to Ending conversion practices in Scotland: consultation
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Defining conversion practices for this legislation

1 Do you support our approach to defining conversion practices which focuses on behaviour motivated by the intention to change or suppress a person's sexual orientation or gender identity?

No

2 Please give the reason for your answer to Question 1.

Please give us your views:

I am Laura Haynes, Ph.D., psychologist, representing the International Foundation for Therapeutic and Counselling Choice (iftcc.org), headquartered in London, for which I am on the executive board, am the USA Country Representative, and am the Chair of the Science and Research Council. We train and serve professionals and pastoral counselors in about 34 nations. Thank you for the opportunity to share our concerns about the proposed "conversion practices" ban.

We believe the intention of a mental health professional, pastor, or parent to help someone desiring to reduce ("suppress") or change same sex or gender discordant feelings, behaviors ("expressions"), or identities should not be banned. The submission says it is based on a literature review and on meeting with stakeholders. We believe there are serious gaps in that literature review resulting in fatal errors in the proposed plan which we will discuss here under Question 2. We also believe there are significant gaps resulting from stakeholders who it appears were excluded from meetings, at least from proposal information, whom we will discuss under Questions 18 and 32. If the testimonies of people

who benefitted from safe and effective change through pastoral or professional care and research into their benefit from this care had been included, we believe the proposal of a ban would never have happened. We believe that, instead, the government would support the education and training we provide internationally in ethics, research, and evidence-based skills for pastoral and mental health professionals who bring about this helpful counseling.

The exclusion of these stakeholders and their needs creates a pattern of structural discrimination against them by means of the ban. We will discuss under Question 18 and Question 32 these groups whose interests and needs we believe have not been appropriately represented.

We note that the term “conversion” practices is a pejorative term invented by people who oppose professional therapy or pastoral care that is open to a client’s goal to manage, decrease, or change undesired same-sex attraction feelings or behaviors or discordant gender identity feelings or behaviors.
Mental health professionals who provide these services generally avoid such a term, except when referring to the language of opponents, and generally use terms such as change-exploring therapy, change-allowing therapy, or, with regard to sexuality, SAFE-T (sexual attraction fluidity exploration through therapy).

We will now, under Question 2, discuss scientific research evidence on same-sex sexuality and discordant gender identity causes and change we believe is foundational to the proposed ban and was overlooked.

The proposed ban states that sexual orientation and gender identity are “inherent”. Inherent implies inborn, or who a person biologically is. The view that same-sex sexuality and discordant gender identity are simply biologically determined and are who a person biologically is has never been scientifically substantiated, and there is no professional consensus in support of it.

The largest-ever gene study, conducted on nearly half a million people, most of them in the United Kingdom, concluded that the genetic contribution to sexuality variability was 32%, far below 100%, therefore not genetically determined. The researchers informed the public, “…knowing someone’s genetic information allows us to guess their sexual behaviour just about as well as guessing with no genetic information at all.” They explained, “Behavioural 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…." (Genetics of Sexual Behavior, 2019, for Ganna et al., 2019)

The largest-ever meta-analysis of twin studies conducted over 50 years and reporting on over 14 million twin pairs across 39 different countries remarkably also found the genetic contribution to sexuality variation is 32%. This figure is well below average for traits therapists help people manage, decrease, or change every day. Psychiatric traits averaged 46%, and all traits studied averaged 49%. The genetic contribution to sexual attraction variability, 32%, is virtually equal to the genetic contribution to religion and spirituality, 31%. There is no genetic reason why a person's sexual identity is any more inherent than their religious identity. (Polderman et al., 2015 and the article's website link to MaTCH)

Among identical twins, if one has same-sex sexuality, the other does also in 14% of twin pairs. (Pairwise concordance of 14% calculated from 24% probandwise concordance that is used to calculate 32% genetic contribution to sexuality variation. Bailey et al., 2016, p. 76, Table 4 caption on p. 75) One study found that among identical twin pairs where one twin was "transsexual", the other was also in 28% of the pairs. (M. Diamond, 2013, Table 5 shows 28%, corrects 20% shown in the abstract) Twins share genes, prenatal hormones, maternal prenatal factors, number of older brothers, and prenatal environmental factors known and unknown. Biological influences taken together do not determine that someone will have same-sex attraction or gender discordance.

Theories of biological causes of sexuality and gender identity are actually theories that biological influences cause a boy to be born less masculine or a girl to be born more masculine. These traits, however, do not equal same sex attraction feelings or discordant gender identity feelings. There have to be more influences to get to same-sex sexuality or gender discordance.

The American Psychological Association's APA Handbook of Sexuality and Psychology accepts that the development of same-sex sexuality and gender discordance is multifactorial, not simply biologically determined, and includes life experiences. It says, "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors." (Rosario & Scrimshaw, 2014, in APA Handbook, vol. 1, p. 583).

Regarding gender identity, the APA Handbook of Sexuality and Psychology

transgender identity is “most likely the result of a complex interaction between biological and environmental factors.” (Bockting, 2014, in APA Handbook, vol. 1, p. 743) A global consensus statement of endocrine societies around the world said there is no consistent evidence that the brains of gender discordant people are different from the brains of gender concordant people. It says there is no biological marker for discordant gender identity, meaning there is no biological thing has been found that is gender identity that another person can find by looking at a person’s brain or conducting a biological test. They said gender identity development is “biopsychosocial”. (Lee et al., 2016) The American Psychiatric Association’s Diagnostic and Statistical Manual, Fifth Edition, Text Revision agrees that gender dysphoria is not an intersex condition of the brain and says it develops from an interaction of biological, psychological, and social influences. (APA, 2022, pp. 511, 517)

Same-sex attraction and gender discordance are not simply biologically determined, and they commonly change through experiences in life. The APA Handbook of Sexuality and Psychology (2014, vol. 1) accepts this, saying, “…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.” (Diamond, p. 636) “Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation.” (Rosario & Scrimshaw, p. 562) “Over the course of life, individuals experience the following: …changes or fluctuations in sexual attractions, behaviors, and romantic partnerships….” (Mustanski et al., p. 619)

These changes in sexuality are abundantly established in the UK and internationally by several large (1,000 to over 22,000 participants) longitudinal (6 to 10 years) studies. (Dickson et al., 2003; Dickson et al., 2013; Hu & Denier, 2023b; Hu, Xu, & Tornell, 2015; Kaestle, 2019; Mock & Eibach, 2012; Ott et al., 2011; Savin-Williams and Ream, 2007; Savin-Williams et al 2012)

Change is especially common for people who experience both-sex attraction, and most same-sex-attracted people by far are both sex attracted. This is also accepted by the American Psychological Association’s APA Handbook of Sexuality and Psychology. It says, “Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical ‘type’ of sexual-minority individual….Individuals with nonexclusive

patterns of attraction are indisputably the ‘norm,’ and those with exclusive same-sex attractions are the exception.” This pattern has been found internationally (Diamond, 2014, vol. 1, p. 633).

Even some people who experience exclusive same-sex sexuality also experience change. More than a quarter of lesbians (27%) came to experience opposite-sex attraction over a 6-year, nationally representative study in the US. (Savin-Williams, 2012) Additionally, even some men who were in exclusively same-sex relationships had some opposite-sex attraction according to a study based on the same US data set. (Kaestle, 2019, p. 817)

Since both sexuality and gender feelings can change through life experience, individuals who experience these changes, professional therapists, and researchers should in principle be able to identify influences that are leading to these changes. We present research under Question 32 showing that some people safely become able to manage, reduce, or change same-sex sexuality through professional therapy or religious-mediated support. We also present evidence that childhood gender discordance may resolve through professional psychotherapy. Therefore, the key is to provide training so that help provided is research-based and ethical. We believe that professional mental health care provided for any therapy goal should be non-abusive, non-aversive, non-coercive, and not give guarantees of change. The international Foundation for Therapeutic and Counselling Choice exists to train professional and pastoral counselors in order to provide ethical and skillful support for those who seek change. We believe the research evidence supports that the intention to provide these services should not be banned.

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Suppression

3 Do you think that legislation should cover acts or courses of behaviour intended to 'suppress' another person's sexual orientation or gender identity?

It should not be covered

4 Please give reasons for your answer to Question 3.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 18, and 32.

The submission mentions the Memorandum of Understanding (MoU). The MoU does not have professional consensus from members inside the signatory organizations or from government health authorities outside the MoU for its affirmative-only treatment viewpoint.

Dr. Cass reported in her interim report,

"Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS [Gender Identity Dysphoria Services] is not just a reflection of local service capacity problems, but also of professionals' practical concerns about

Correction: GIDS [Gender Identity Development Services]

the appropriate clinical management of this group of children and young people." (Cass, 2022, p. 48)

Dr. Cass' interim report has moved NHS England away from the “predominantly affirmative, non-exploratory approach” that had been followed at the Tavistock to a “fundamentally different service model” (p. 17) that will treat gender dysphoria more in line with how other paediatric psychiatric conditions are treated. (p. 69) She notes, “Many authors view gender expression as a result of a complex interaction between biological, cultural, social and psychological factors.” (p. 28) The NIH England Interim Service Specification reiterates these points. (NIH, 20 October 2022)

NHS England is now more aligned with government health authorities of Sweden, Finland, Florida (US), and apparently Denmark that also are moving away from the affirmative-only approach and prioritizing psychotherapy based on research. Increasingly, professional organizations also have made this change, for example the National Association of Practicing Psychiatrists (Australia), Royal Australian and New Zealand College of Psychiatrists, Italian Psychoanalytic Society, Indiana State Medical Association (US), and the National Academy of Medicine (France).

There is no way to clarify what is or is not "conversion therapy" under a therapy ban. Even the professional organizations have not been able do it. Therapists have not been willing to take the risk of treating gender dysphoric patients at all, contributing to the enormous backlog of chronically untreated patients waiting for services at GIDS and the closing of the Tavistock. We have seen that the therapy ban of the MoU has decreased access to care for people it intended to help. The Scottish proposed ban is another affirmative-only plan only far more aggressive. A therapy ban by the government of Scotland would further worsen access to care.

Overview of proposals

5 Do you support or not support an approach which uses a package of both criminal and civil measures to address conversion practices in legislation?

Do not support

6 Please give reasons for your answer to Question 5.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Offence of engaging in conversion practices: the provision of a service

7 What are your views on the proposal that the offence will address the provision of a service?

Do not support

8 Please give reasons for your answer to Question 7.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Offence of engaging in conversion practices: coercive course of behaviour

9 What are your views on the proposal that the offence will address a coercive course of behaviour?

Do not support

10 Please give reasons for your answer to Question 9.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Offence of engaging in conversion practices: harm

11 What are your views on the requirement that the conduct of the perpetrator must have caused the victim to suffer physical or psychological harm (Including fear, alarm or distress)?

Do not agree

12 Please give reasons for your answer to Question 11.

Please give us your views:

We oppose the proposed ban altogether based on

research we present for Questions 2, 4, 18, and 32.

There are already laws that deal with abusive behaviors,

and we oppose abusive behaviors.

Offence of engaging in conversion practices: defence of reasonableness

13 Do you agree with the inclusion of a defence of reasonableness?

Not Answered

14 Please give reasons for your answer to Question 13.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Offence of engaging in conversion practices: proposed penalty

15 Do you agree with the proposed penalties for the offence of engaging in conversion practices?

Do not agree

16 Please give reasons for your answer to Question 15.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Criminal offences – additional considerations

17 Do you agree that there should be no defence of consent for conversion practices?

No

18 Please give reasons for your answer to Question 17.

Please give us your views:

The proposed “conversion practices” ban creates a false dichotomy that affirmative

therapy respects autonomy but change-exploring therapy is coercive. The claim is made that “conversion” practices “often use threats, power, force, intimidation or control to push someone to change or stop their identity.” This is a clear indication that the authors of this bill have not met with all stakeholders and do not have a representative understanding of ethical change exploring therapy to which people may freely and really consent. The authors’ perspective appears to be that no one could possibly freely and rationally choose to explore their capacity for change, perhaps especially religious people, a view that is itself oppressive and discriminatory and not justified by the best-available research.

The proposed ban disparages the capacity and agency of citizens to choose how they wish to live out their sexuality and gender identity and to consent to help to live as they choose, and it forbids recognizing any exceptions to its disparagement. This is egregious government control of the sexuality and gender identity of citizens. Remarkably, it is a must-stay-gay-and-must-stay-transgender law.

There are rational reasons why some people want help to manage, decrease, or change same-sex behaviour or discordant gender expression, and they can reasonably consent to it.

First, some people identified as LGBT and had LGBT experiences and did not find them fulfilling. They want change. Karen & Wade, 2010)

Second, some people want help to manage, reduce, or change behavior and the desire to engage in it that is risky, unhealthy, unlawful, unfulfilling, endangering their marriage to the spouse they love and risking family breakup for their children, or psychiatrically disordered. Such a therapy goal is ordinarily accepted when the behaviour is directed toward a person of the opposite-sex or is engaged in by someone whose gender identity matches their sex. The same help should be permitted when the behaviour is directed toward a person of the same-sex or is expressed by a person who is gender identity is discordant to their sex, without discrimination. Help to decrease or change these behaviors is most likely to be successful if the desire to engage in them is decreased. It would be difficult, if not impossible, to help someone change such behaviors while assuring that the desire to engage in them does not decrease, as feelings and behaviors are inextricably inter-connected. Further, if help is permitted in any of these instances, anyone should have the right to this help for whatever reason they wish, without discrimination. It is unjust for the government to forbid citizens to walk away

from sexuality or gender experiences or practices that do not work for them and to have help to do so.

Several studies of randomized controlled trials of therapies conducted by LGB-affirmative therapists and lay-counsellors have found that men who have sex with men have effectively reduced same-sex partners for the purpose of decreasing HIV risk. (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Reback & Shoptaw, 2014; Nyamathi et al., 2017) Men who were fathers, and men for whom same-sex behaviour was inconsistent with their values (researchers measured this inconsistency as “homonegativity”) were especially successful in reducing same-sex partners (Nyamathi et al., 2017). A “conversion practices” ban would criminalize these LGB-affirmative therapists and lay counselors who intended to help these men decrease their same sex partners. It is absurd to criminalize standard therapies and lay counselling that protect health. People should be allowed therapy to reduce same-sex behaviour to protect their health or for whatever reason they wish without discrimination.

The lead author of the WPATH Standards of Care, Versions 7 and 8, Coleman, specializes in treating compulsive sexual behaviour disorder, an accepted diagnosis in the International Classification of Diseases, 11th Edition (WHO, 2022). Hence, he helps people suppress or decrease sexual behaviour, and for some people, he is helping them decrease same-sex behaviour. Apparently, authorities with the ICD believe people can consent to suppression or reduction of their sexual behaviour. According to the proposed “conversion” practices ban, the lead author of the WPATH standards of care who intends to help people suppress same-sex expression would be criminalized if he did so in Scotland, the UK, or anywhere in the world. Individuals should be able to get this help when their sexual behaviour is directed toward the same-sex, not only when it is directed toward the opposite sex, and also for whatever reason they wish without discrimination.

Third, some want to stop same-sex behavior or transgender identity or behavior that is putting at risk their marriage and family that hold a higher priority for them. They should be permitted help they want to protect their marriage to the opposite-sex spouse they love and to protect their family from break-up so they can go on being full-time moms or dads. See our response to Question 32 for more research on successful psychotherapy for them. Scottish law should not take away the rights of citizens to support and resources that may include professional psychotherapy, pastoral care, religious support ministries, and family support to help them protect their marriage and family.

Fourth, some people feel their same sex attraction or behaviour or gender discordance is not inherent and not who they most truly are but was caused by underlying sexual or gender trauma or mental health problems. They want the right to heal and be their authentic self. The American Psychological Association's APA Handbook of Sexuality and Psychology (APA, 2014) accepts that causes of same-sex sexuality include "psychoanalytic contingencies" (Rosario and Shrimshaw, chapter 18 in vol. 1, p. 583) and says childhood sexual abuse has potentially "causal links" to having same-sex partners for some (Mustanksi et al., Chapter 19, in vol. 1, pp. 609-610). Research internationally has found that psychiatric disorders, neurodevelopmental disabilities, self-injuring behaviour, or suicidality preceded onset of gender dysphoria or incongruence, therefore may predispose to it, precipitate it, perpetuate it, or be causal for it. (Becerra-Culqui et al., 2018; Kaltiala et al., 2015; Bechard et al., 2017; Kozlowska, McClure et al., 2021 together with complimentary article Kozlowska, Chudleigh et al., 2021) Some want the right to explore the context in which their sexual or gender feelings emerged, to receive treatment for potential underlying pathological causes, and to heal. People should be permitted help to heal.

Finland's recommendation (Council for Choices, 2020) for treating adolescent gender dysphoria says,"In adolescents, psychiatric disorder and developmental difficulties may predispose a young person to the onset of gender dysphoria." Further, it says, "Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." (chapter 6) It importantly recommends, "The first-line intervention for gender variance during childhood and adolescent years is psychosocial support and, as necessary,
gender-exploratory therapy and treatment for comorbid psychiatric disorders." (chapter 7) It would be absurd for Scotland to criminalize therapy that Finland recommends based on research and leading clinical experience, and, for gender dysphoric adolescents, it would be a disaster.

There is evidence that replacing change-exploring therapy with affirmative interventions has harmed, and not helped, LGB-identified people. The originator of the minority stress theory, Ilan Meyer, and colleagues (2021) conducted what they believed to be the first study of the minority stress theory that is nationally representative, large scale, and uses questions and measures that are specific to this population, thus acknowledging that previous research had not met these

standards. They found that, over 50 years in the US of progressively and dramatically increasing societal affirmation (which would include increasing affirmative therapy and discouraging of change-exploring therapy) and earlier onset of coming out and sexual relationships, the psychological stress, reported experiences of physical violence, and suicidality of the LGB-identified population have progressively worsened. The authors said the study did not support the minority stress theory that these are caused by the social environment, and that changing the social environment would improve mental health for LGB-identified people. They also said their study was consistent with other evidence that minority stress is worsening. Replacing therapy that explores potential underlying causes of same sex attraction and behavior with therapy that denies and neglects underlying causes has not helped. The proposed ban would coerce Scotland down this harmful path. The study reported that the prevalence of "conversion therapy" has been unchanged for 50 years at 6% to 8% (odds ratio hovering around 1). Therefore, the existence of change-exploring therapy cannot be the cause of the progressively and dramatically increasing mental health problems in LGB-identified people.

The authors did not consider possible alternative explanations for increased experiences of violence related to sexual orientation, such as an earlier beginning of sexual behaviour potentially being related to more sexual partners and therefore more risk of violence in early and late adolescence and young adulthood (CDC, 27 Jan 2023)

In contrast to progressively and dramatically increased affirmation being accompanied by worse psychological stress and suicidality, Sullins found, using the very same data set, that "sexual orientation change efforts" ("SOCE") did not increase suicidality in people who did not change sexual orientation (they still identified as LGB) and may have reduced it, potentially dramatically. He corrected Blosnich and colleagues who had earlier made the mistake of concluding from this data set that SOCE caused suicidality that occurred before SOCE. (Blosnich et al., 2020; Sullins, 2022; 2023a; 2023b) Professional organizations that have opposed change-exploring therapy have relied on the erroneous research of Blosnich and other studies that employed the same shoddy methods and made the same mistake.

Michael Bailey, a leading gay researcher into LGBT issues, published an article in 2020 with a title that raised this challenge: "The Minority Stress Model Deserves Reconsideration, Not Just Extension". In the article he said,

Twenty years ago, I commented on two of the first careful epidemiological studies showing that nonheterosexual people were at increased risk of some mental health problems. I noted that although the idea that these problems arise from "societal oppression"—what has become known as "minority stress"—was certainly possible, other explanations were also possible and should be considered. I concluded that "it would be a shame—most of all for gay men and lesbians whose mental health is at stake—if sociopolitical concerns prevented researchers from conscientious consideration of any reasonable hypothesis (Bailey, 1999)."

I am afraid that my fear has largely been realized. The minority stress model has been prematurely accepted as the default explanation for sexual orientation-associated differences in mental health. Yet minority stress research has not generated findings uniquely explicable by the model, and it has ignored the model's serious limitations. I understand discomfort about and hesitancy to study alternative models, such as the one proposed above [in Bailey's article]. But acceptance of an incorrect explanation helps no one.

The proposed counseling ban follows the unproven minority stress theory and omits research evidence such as that just presented that social affirmation has not improved mental health for LGB-identified people but change-exploring professional and pastoral counseling has. The ban would be a disaster.

Fifth, some want help to live consistently with their religious beliefs that should be respected. Please see research presented at Question 32 regarding safe and successful religiously mediated intervention for them.

There also is not a research or professional consensus in support of the ban. Our professional organization, the International Foundation for Therapeutic and Counsellilng Choice, and many professional organizations around the world oppose banning change-exploring therapy for people who want to explore their capacity to manage, decrease, or change undesired same-sex attraction feelings or behaviors or discordant gender identity feelings or behaviors. (Haynes, 2024) There is no scientific justification or professional consensus for banning ethical professional and pastoral conversations for these counseling and life goals.

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19 Do you have any other comments regarding the criminal offence?These are set out in parts 7 and 8 of our full consultation document.

Please give us your views:

Removing a person from Scotland for conversion practices

20 What are your views on it being a criminal offence to take a person out of Scotland for the purpose of subjecting them to conversion practices?

Do not support

21 Please give your reasons for your answer to Question 20.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

22 What are your views on the proposed penalties for taking a person outside of Scotland for the purposes of conversion practices?

Do not support

23 Please explain your answer to Question 22.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Conversion practices as an aggravating factor for existing offences

24 What are your views on the proposal that conversion practices should be an aggravating factor for existing offences?

Do not support

25 Please explain your answer to Question 24.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

A new civil order relating to conversion practices

27 What are your views on the purposes of the proposed conversion practices protection order?

Do not support

28 Please explain your answer to Question 27.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

A new civil order relating to conversion practices: considerations

29 Do you agree or disagree with the proposals for who should be able to apply for a conversion practices civil order?

Do not agree

30 Please explain your answer to Question 29.

Please give us your views:

We oppose the proposed ban altogether based on research we present for Questions 2, 4, 18, and 32.

Wider

recommendatio

ns Impact

assessments

32 Do you have any views on the potential impacts of the proposals in this consultation on equality by:

a. Age, c. Gender reassignment, f. Race, g.

Religion and belief, i. Sexual orientation If

you wish, please expand on your answer.:

AGE. NHS England (March 2024), Sweden (Georgas et al., 2018; Ludviggson et al., 2023), and Florida (Florida Medicaid, June 2022) have conducted systematic research reviews and concluded that research support for affirmative treatment for gender dysphoria in children and adolescents is of poor quality and not a basis for recommending medical interventions. The World Health Organization (Jan 2024) said regarding its planned gender interventions guideline, “The scope will cover adults only and not address the needs of children and adolescents, because, on review, the evidence base for children and adolescents is limited and variable.” Alternate treatment for gender dysphoria is much needed and will be needed more than ever as NHS England moves from affirmative, non-exploratory interventions to prioritizing psychotherapy for treating gender dysphoria in children and adolescents.

Fortunately, the best available research evidence shows that childhood gender dysphoria usually resolves and, further, supports that gender dysphoria or discordant gender identity change efforts for children are effective. The proposed

“Conversion practices” ban would prohibit this safe and effective therapy.

Childhood gender dysphoria most often resolves for 50% to 98% in studies recognized in the American Psychiatric Association’s Diagnostic and Statistical Manual, Fifth Edition, Text Revision (APA, 2022, DSM-5-TR, p. 516 based on persistence rates reported) and an average of 85% according to the Endocrine Society Clinical Practice Guideline co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association of Transgender Health (Hembree et al., 2017, p. 11).

Researchers have unanimously found in 11 out of 11 studies across 4 decades and a variety of countries and methods, that childhood gender dysphoria overwhelmingly resolves by adolescence or early adulthood— on average 85%. (Singh, Bradley, & Zucker, 2021; Steensma et al., 2010; Ristori & Steensma, 2016; research review: Zucker 2018) A challenge to this consensus has been rebutted. (Zucker, 2018) Per review, 93% of children who met diagnostic criteria at subthreshhold desisted, and 67% who fully met diagnostic criteria at threshold desisted (Zucker, 2018), for an overall average of 85% or more desisted.

In the earliest 10 of these studies, children were given psychotherapy that was not affirmative but rather treated stressors or disorders that might prevent gender identity resolution. (Cantor, 2022) In the most recent, largest, and methodologically most rigorous of these studies, 88% of boys came to identify with their sex. The children in this study attended the Gender Identity Service in Toronto, Canada. At this center, gender dysphoric children were given therapy for the expressed purpose of evaluating and treating the influences or experiences that led them to feel they would feel more valued or safe as another sex and of helping them “become comfortable in their skin”, to identify with their sex. (Zucker et al., 2012) The children overwhelmingly came to accept their sex.

A conversion practices ban would forbid children to have this therapy and would punish anyone who would help them receive it in Scotland, the UK, or anywhere in the world. There is no scientific justification for this; it would be an egregious miscarriage of justice.

Prohibiting gender dysphoric adolescents and adults the same access to therapy to become comfortable with and identify as their sex if they wish leaves them to

live with gender dysphoria or take hormone and surgery interventions for which the World Professional Association for Transgender Health, Standards of Care, Version 8 (p. S150) acknowledges there is no long term research on the effects after 6, 7, 8 or more decades. There are now, however, several longitudinal population registry studies that have found medical gender interventions at all ages do not improve mental health or may even make it worse. (Hisle-Gorman et al., 2021; Glintborg et al., 2023; Dhejne et al., 2011; Branstrom & Pachankis, 2020, with correction; Kaltiala et al., 2023) One study found suicides had not increased after an average of 6.5 years post gender intervention hormones and surgeries. (Ruuska et al., 2024), consistent with the Dhejne study that found suicides did not rise until after 10 years (then rose to 19 times higher than for representatives of the general population). However, it is possible the 38% who proceeded to medical gender interventions were preselected to have fewer mental health problems.

These studies do not justify prohibiting alternate treatment through psychotherapy to resolve gender dysphoria or incongruence.

The proposed therapy ban would, without scientific justification, forbid effective psychotherapy for children that is all the more needed as NHS England moves away from non-exploratory affirmative interventions. Psychotherapy and pastoral care that support individuals to accept and embrace their inherent sex should continue to be permitted for children and for any desiring person at any age without discrimination as to age.

GENDER REASSIGNMENT SURGERY

In emerging research, people who had gender reassignment surgery and then detransitioned are reporting that many want therapy to help them resolve their gender dysphoria and the actual causes of their gender dysphoria after medical gender interventions did not help them. They are reporting mental health professionals did not evaluate for the causes of their gender dysphoria or try to treat potential underlying causes. They came to understand their gender dysphoria was caused by trauma, mental health disorders, or other causes. They have reported mental health professionals are afraid of them and have “no clue” how to help them. They should have the right to psychotherapy to help them toward their therapy and life goals. There is no scientific justification for prohibiting psychotherapy to resolve gender dysphoria or incongruence for detransitioners. Gender dysphoric or incongruent people who do not want body-harming medical interventions for any reason, not only detransitioners, should also be supported to have psychotherapy to explore their potential to resolve their gender dysphoria

or incongruence and accept their inherent sex, without discrimination. (Vanderbussche, 2021; Littman, 2021; Roberts, 2022; Boyd et al., 2022) There is no justification to refuse them ethical psychotherapy and pastoral care.

RACE

According to the National LGBT 2017 Survey, Blacks are the race that most uses religious change exploring support. The survey asks only LGBT-identified people whether they experienced “conversion therapy” without defining it in the survey or asking whether if was harmful in any way.

A review of the National LGBT 2017 Survey concluded,

“Restriction of conversion therapy would thus have a disparate impact on ethnic minorities in Britain, among whom it is much more widely used than among the dominant White population. The GEO National LGBT 2017 Report concedes that 'there are gaps in the studies into conversion therapy for sexual orientation about the experiences of … people from ethnic minority groups undergoing conversion therapy.' Due to its much higher use, conversion therapy is less likely to be considered negative among ethnic minorities, and there is no evidence that it is harmful. Restriction of access to such therapy on the basis of the experience of White LGBT persons alone may be considered a form of ideological colonization of Black, Asian and Other minority groups in the British population.” (Sullins, March 2024, p. 7)

RELIGION AND BELIEF

The proposed conversion practices ban is not built on research that is inclusive or representative of all people who experience same sex attraction or gender discordant identity. The proposal consistently refers to “LGBT people”. Population-based studies and studies by a remarkable research team of LGB-affirming researchers and change-exploring-therapy affirming researchers working together has found a significant sub-population that the research team named “non-LGB-identified”. Since non-LGB-identified people reject an LGB identity, they are largely or entirely excluded from surveys of people who identify as LGB or LGBT that claim harm from “conversion” practices. Non-LGB-identified people were explicitly excluded from the National LGBT 2017 Survey. Non-LGB-identified typically are religious and attend religious services weekly, while LGB-identified typically do not. For non-LGB-identified, religion is associated with mental health, contrary to the

minority stress theory, while for LGB-identified there is almost no such association. Also, generally unlike LGB-identified, non-LGB-identified typically do not believe their same-sex attraction is inborn. Rather, they see their same-sex attraction as feelings they have, not who they are, not their identity. As a result, their responses on homonegativity questionnaires likely represent assent to religious beliefs, not beliefs about self or shame. Non-LGB-identified place value on sexual abstinence or opposite-sex marriage. Non-LGB-identified are the population that most experiences therapy or counseling with a goal to manage, reduce, or change same sex attraction or behaviour. (APA Task Force Report, 2009, p. 25; Rosik et al., 2021a; Sullins, Rosik, & Santero, 2021, Pela & Sutton, 2021; Jones & Yarhouse, 2012; Karten & Wade, 2010; Byrd, Nicolosi, & Potts, 2008; GEO, 2018) They find most goals of change-exploring therapy helpful. They will be the people most affected by a therapy ban that is largely based on viewpoints of LGBT-identified people.

More than 2,500 pastors in the UK have signed a statement in opposition to therapy bans. (Christian Ministers, 4 Feb 2022) Bishops of the Catholic Church in Scotland said a ban “would criminalize mainstream religious pastoral care, parental guidance, and medical or other professional intervention relating to sexual orientation ‘unless it was approved by the State as acceptable.’” (Collins, 10 Jan 2024)

While research on the non-LGB-identified population has largely studied people who identify as Christian, Catholic, Jewish, or Mormon, findings in the National LGBT 2017 Survey show that Hindus and Muslims will be the most affected by a therapy ban within the UK. A joint press release by the British Board of Scholars & Imams, the Muslim Council of Scotland (SCIO), & the Muslim Council of Wales announced the publication of “Conversion Therapy: What Should Muslims Know?” a pamphlet available online that provides guidance for Muslims and critical evaluation of therapy bans proposed in their regions. (Three Leading Muslim Organizations, 8 March 2024) The international Organization of Islamic Cooperation (OIC, 2016) said, “We believe that the concepts of sexual orientation and gender identity are not recognized under any international instruments, and run counter to the values and teachings of many religions and beliefs including Islam.” The OIC unequivocally rejected a paper promoting a therapy ban that an independent volunteer individual submitted to the Human Rights Council of the United Nations. The OIC has 57 nation members and is the largest organisation of nations in the world next to the United Nations (OIC, no date) As a result of the

presence and influence of these nations along with others, we can be sure there is not a United Nations position in opposition to change-exploring therapy for undesired sexual or gender feelings or behaviours. The OIC is the collective voice of the Muslim world.

Population-based research (Barringer & Gay, 2017) and research by an ideologically diverse research team (Lefevor, Davis, et al., 2021; Lefevor, Sorrell, et al., 2019; Rosik et al., 2021) has found that non-LGB-identified people who live by their traditional faith are no less happy, mentally healthy, satisfied with life, and flourishing than LGB-identified people of liberal faith or no faith. Therapists, counsellors, teachers, parents, religious leaders, and faith-based communities can help children and adults experience this flourishing. They should not be criminalized for doing so.

Restriction of access to change-exploring therapy for sexuality or gender identity on the basis of the experience of primarily liberal religious or non-religious, White, LGBT-identifying persons may be considered a form of ideological colonization on people of the major world religions.

SEXUAL ORIENTATION

The proposed therapy ban will take away availability of appropriate support for the marriages of LGBT-identified people that is based on research on same-sex attraction.

We presented research under Question 2 showing that same sex attraction, behavior, and identity—all 3—commonly change for men and women, adolescents and adults, and change is especially common for people who experience both sex attraction.

We now add that most both-sex attracted people who are in a marriage relationship are with the opposite sex. The UK Office of National Statistics in 2020 reported that, among people who were married, 94% of bisexual identified persons were with the opposite sex, 96% of “other non-heterosexual persons” (a census category that included transgender identified people), and 28% of “gay and lesbian” identified persons, for an overall rate of 65% of LGBTQ+ identified people who were married were with the opposite sex. Thus, the number of LGBTQ+ identified people in the UK who are in an opposite-sex marriage is not negligible—255,000 people, comprising 41% of all LGBTQ+ identified people who were not single. (Sullins, GEO Survey reanalysis, 2024)

The two most common reasons same-sex attracted people give for why they are in change-exploring therapy are (1) to protect their marriage to the opposite-sex spouse they love and to protect their family so they can go on being full time moms and dads, or to prepare for an opposite-sex marriage to which an adolescent or adult aspires, and (2) to live consistently with their religious faith by being either abstinent or in an opposite-sex marriage. (Pela & Sutton, 2021; Sullins, Rosik, & Santero, 2021) The rate of satisfaction in opposite-sex marriages of same-sex attracted people was 80% in a U.S. study. (Lefevor, Beckstead, et al., 2019)

They may need or want therapy to help them be faithful in their marriage. Research has found that fathers were especially successful in decreasing same-sex partners in a randomized, controlled trial of LGB-affirmative therapy for reducing HIV risk (Nyamathi et al., 2017) and in a study of mostly religious men in change-exploring therapy for protecting their marriage and family. (Sullins, Santero, & Rosik, 2021). In change-exploring therapy, 41% of the men were married, nearly all with children, on average 3 children each. The prevalence of married men who were engaging in same-sex behaviour prior to therapy was 71% and plunged to 14% after therapy. What this means to these men, their wives, and their children can hardly be expressed. For all men in the study, 69% decreased same-sex attraction. Before therapy, only 11% of the men had opposite sex attraction that was equal to or greater than their attraction to the same-sex. That changed to 51% after the therapy, enabling them to achieve their goals to be in an opposite-sex marriage or be abstinent more easily and enjoyably. Even a partial change can change a life. Change need not be from exclusively same-sex attracted to exclusively opposite-sex attracted to help someone live as they wish. In this study, benefits greatly outweighed any harms. For these men, depression and suicidality decreased, and self-esteem increased.

Yet, the Submission Report said, “The Group [Expert Advisory Group on Ending Conversion Practices] recommends that the definition of conversion practices … must be wide enough to encompass any treatment, practice or effort that aims to change, suppress, and/or eliminate a person's sexual orientation, expression of sexual orientation, gender identity, and/or gender expression.” It explicitly states there may be no exceptions to its assertion that no one can consent.

The Group’s recommendation is scientifically unjustified. The best-available

research supports that change in same-sex attraction or behavior can occur safely through therapy and faith-based ministry. Research from which the evidence comes includes 4 randomized, controlled trials (Shoptaw et al., 2005; Shoptaw et al., 2008; Reback & Shoptaw, 2014; Nyamathi et al., 2017) and 2 prospective, quasi-experimental, naturalistic longitudinal studies (Pela & Sutton, 2021; Jones & Yarhouse, 2011). Unlike typical studies that claim harm, researchers in these longitudinal studies actually documented that the participants were in professional therapy in one study and in religious support groups in the other study, and their sexual attraction and psychological well-being were assessed repeatedly in real time before, during, and after they went through these helpful interventions to make accurate comparisons.

Whatever limitations there may be in some of these studies, they are in fact and by far methodologically the best available research on change in same-sex sexuality and psychological well-being through professional psychotherapy and faith-based support. Their findings do not justify the proposed ban on these interventions.

The claim of the Group that individuals could not possibly freely consent to change-exploring therapy or pastoral counseling based on self-knowledge, desire to protect their marriage to the person they love and to protect their family, and love of the beauty of their religion that brings them happiness is in itself oppressive and discriminatory. Some people have regretted the years they did not seek change-exploring therapy because of external pressure from their family and society not to explore their capacity for change, resulting in loss of years of their life that they could have lived as they do now.

A therapy ban would harmfully and unjustly affect access to help for LGBT-identified people (UK ONS, 2020) and non-LGB-identified people (Pela & Sutton, 2021; Sullins, Rosik, and Santero, 2021) who are not single, their marriages, and their families.

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32 Do you have any views on the potential impacts of the proposals in this consultation on children and young people, as set out in the UN Convention on the Rights of the Child?

Please give us your views:

33 Do you have any views on the potential impacts of the proposals in this consultation on socio-economic inequality?

Please give us your views:

34 Do you have any views on potential impacts of the proposals in this consultation on communities on the Scottish islands?

Please give us your views:

35 Do you have any views on the potential impacts of the proposals in this consultation on privacy and data protection?

Please give us your views:

The proposal is to criminalize private, consensual conversations about private experiences. This opens the possibility of police spying on people's private conversations to see if they could possibly be described as "conversion" practices. This is an egregious invasion of privacy.

36 Do you have any views on the potential impacts of the proposals in this consultation on businesses and the third sector?

Please give us your views:

37 Do you have any views on the potential impacts of the proposals in this consultation on the environment?

Please give us your views:

About you

What is your name?

Name:
Laura Haynes, Ph.D.

What is your email address?

Email:
laura.haynesphd@iftcc.org

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
International Foundation for Therapeutic and Counselling Choice

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Yes

I confirm that I have read the privacy policy and consent to the data I provide being used as set out in the policy.

I consent

Evaluation

Please help us improve our consultations by answering the questions below. (Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?:
Neither satisfied nor

dissatisfied Please

enter comments

here.:

I appreciate very much the opportunity to give a submission

on behalf of myself and our organization. Thank you! The

speed of the website for the submission was very slow,

perhaps because of heavy traffic on the last day.

The questions covered a wide range of points, but they appeared quite biased.

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?: Neither satisfied nor dissatisfied

Please enter comments here.:

The speed was very slow, perhaps due to heavy traffic on the last day of the submission.