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EXPERT REPORT ON THE COALITION AGAINST CONVERSION THERAPY MEMORANDUM OF UNDERSTANDING ON CONVERSATION THERAPY IN THE UK

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Expert Report on
The Coalition Against Conversion Therapy
Memorandum of Understanding on
Conversation Therapy
In the UK

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Synopsis of Author's Background

I am a Phi Beta Kappa graduate of the University of Oregon and earned my doctorate in clinical psychology from Fuller Graduate School of Psychology. I am currently a psychologist and director of research at Link Care Center in Fresno, California, as well as a clinical faculty member at Fresno Pacific University. I have professional interests that include the psychological care of missionaries and clergy, dissociative disorders, and homosexuality. I have published more than 50 articles in peer-reviewed journals on these and other topics. I have served as President of the Western Region of the Christian Association for Psychological Studies (CAPS) and the Alliance for Therapeutic Choice and Scientific Integrity.

INTRODUCTION

1. This report concerns the Memorandum of Understanding (MoU) published in 2017 by the Coalition Against Conversion Therapy.

2. It has been prepared following the instructions of Andrew Storch Solicitors Ltd who act for Dr Michael Davidson.

3. I have been instructed to address the following matters in this report:

    a. Please provide a scientific critique of the MoU.
    b. Should this continue to be adopted, what harm might be caused to prospective patients/clients.

4. For the preparation of this report, I had access to the following:
    a. Instruction letter.
    b. MoU.

BACKGROUND INFORMATION

5. Ever since the publication of Sigmund Freud's *Three Essays on the Theory of Sexuality*, and 1922, *Certain Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality* there has been a debate on whether sexual "orientation" was innate and immutable or not.

6. There is no UK society or institution that addresses these essential arguments in their literature. Even the Royal College of Psychiatrists held a genetic view of homosexual aetiology. Following challenges raised by Core Issues Trust, the College amended its statement in 2014 recognising not only that change in sexual orientation may happen in a person's life, but that also sexuality is indeed fluid and subject to *"post-natal influences"*.

7. The Church of England's Pilling Commission published shortly after the Royal College of Psychiatrists' revised statement, supported the Core Issues Trust reading of the primary sources and believed that the Royal College had misused these in their reports - which ultimately misinformed the UK on this matter.

8. The 2015 MoU developed around the same time, however, does not reflect these developments, nor does it reflect on the known science.

9. The Coalition Against Conversion Therapy in October 2017 launched the new MoU. Its purpose was to end any attempts to offer 'cures' to transgender people as well as individuals who experience same-sex sexuality. It was launched by Ben Bradshaw MP in partnership with the Coalition Against Conversion Therapy.

10. The Coalition against Conversion Therapy is a group made up of clinical counselling and psychotherapy bodies, including the British Psychological Society, the UK Council for Psychotherapy and Relate.

11. This was launched on the back of the new NfP Synergy research for Stonewall, which suggests that two-thirds of people (68 per cent) are concerned about persons offering conversion therapy.

12. This memorandum followed the launching of the UK Government's LGBT action plan[1], which gave a commitment to end conversion therapy. The Government's national LGBT survey found 2% of LGBT people have undergone conversion therapy, and a further 5% have been offered it.

13. The memorandum position is that conversion therapy in relation to both gender identity and sexual orientation is unethical, potentially harmful and is not supported by evidence. The 2017 MoU follows on from the 2015 MoU and was intended to ensure that:

- **a.** The public are well informed about the risks of conversion therapy.
- **b.** Healthcare professionals and psychological therapists are aware of the ethical issues relating to conversion therapy.
- **c.** New and existing psychological therapists are appropriately trained.
- **d.** Evidence into conversion therapy is kept under regular review.
- **e.** Professionals from across the health, care and psychological professions work together to achieve the above goals.

14. For a full understanding of the MoU, the following document should also be considered: *"Guidance on psychological therapies that pathologize and/or seek to eliminate or reduce same-sex attraction".*[2]

15. However, rigorous research has established that sexual preferences in attraction and behaviour are not inborn and frequently change.

16. Research fails to meet scientific standards and is ideologically biased that purports to show harm from therapeutic or counselling conversations that assist exploration of potential for fluidity or change in same-sex attraction or behaviour.

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[1] https://www.gov.uk/government/news/new-government-action-plan-pledges-to-improve-the-lives-of-lgbt-people--2

[2] https://www.psychotherapy.org.uk/about-ukcp/public-policy/conversion-therapy/

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I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of the Claimants. I have been asked to offer my analysis and opinions regarding the state of science on the issues of sexual orientation and gender identity, with a focus on the published quantitative literature as pertains to the Memorandum of Understanding. The facts in this Declaration are true and correct, and if called upon to testify to them I would and could do so competently.

2. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am also the Director of Research. Attached hereto as Appendix 2 is a copy of my curriculum vitae, which includes my qualifications and publications, including all publications I have authored in the previous ten years.

3. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Appendix 2.

II. SUMMARY AND PRELIMINARY CONSIDERATIONS.

4. With reference to the Memorandum of Understanding (MoU, 2017), I offer below several considerations. I note at the outset that the terminology of **sexual orientation change efforts (SOCE)** and "conversion therapy" used in the MoU are in many ways, misnomers. These terms imply that categorical change (from exclusive same-sex attraction to exclusive opposite-sex attraction) is the goal and the focus, although change typically is on a continuum and can occur without a direct therapeutic focus on sexuality. The term itself, SOCE, also is not clear about what constitutes an "effort" and whether this effort is that of the client and/or the therapist. However, ethical change-exploring talk therapy is client-directed and does not impose goals on the client but seeks instead to facilitate the voluntary, self-initiated goals of the client which sometimes include change. "Conversion therapy" gives the false impression that there is a singular exotic therapy being practised when in fact ethical practitioners in this area utilise a variety of mainstream therapeutic approaches, all centred on and delivered through speech. Finally, these terms do not always distinguish between professionally conducted psychotherapy and religious or other forms of counselling practice, a blurring of categories that carries immense significance for accurately representing change-exploring professional therapies. Unfortunately, SOCE terminology is the current standard vernacular, so I will employ it at times in this declaration to signify change-exploring professional talk therapies, though I recognise that licensed therapists in this area of practice find the language of sexual attraction fluidity exploration or therapy-assisted fluidity to be more accurately descriptive of their work.

5. There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and adults and see change-exploring therapies as a valid option for psychological care, while simultaneously affirming as well the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically levelled against professional SOCE, the information in the present declaration should be sufficient to question the scientific (not to mention clients' rights) merits of the MoU.

6. To summarise my main points:

a. The MoU (2017) offers no scientific evidence in support of its claim of harm. An earlier version of the MoU (2015) cited a research review reported by a task force of the American Psychological Association (2009). The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of therapy censorship often portray it to be. Their one-sided presentation of the science, if indeed they present science, is a byproduct of a pervasive lack of viewpoint diversity within professional organisations and their constituent social scientists as pertains to sexual orientation research. Notwithstanding this demonstrable bias, the scientific literature does not

support the conclusion that voluntary, speech based SOCE causes harm. In fact, the actual research articles reject causal attribution of harm to SOCE as an empirical matter, rendering any pro-SOCE-ban position statements based on the studies at best unreliable and at worst dishonest.

b. Given the empirically determined fact that all therapy includes some risk of harm, and the absence of any empirical data on harm specifically from SOCE therapy, the actual degree of harm attributable to SOCE is unknowable at this time. This is a critical fact of basic research methodology.

c. Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery as pertains to SOCE, as is evident in the highly discrepant methodological standards professional organisations have utilised to evaluate efficacy and harm.

d. An impressive body of scientific data indicates that non-heterosexual sexual orientations should not be viewed as always immutable but are often fluid and subject to change, especially among youth and young adults, and throughout life. Assertions to the contrary should be considered in light of Diamond and Rosky's (2016) observation that, in spite of its scientific inaccuracy, "*Some advocates clearly believe that immutability claims are necessary to advocate effectively for sexual minorities"* (p. 372).

e. The effect of bans often results in the stifling of speech, and mischaracterisations that change-exploring therapists are using aversive practices have been disingenuous.

f. I go on to address the literature on sexual orientation stigma and discrimination, making it clear that justification is lacking for using professional SOCE as a proxy for these terms.

g. I also address the ubiquitous appeals to authority and note the need for healthy scepticism when professional organisations whose leaders lack ideological diversity make scientific claims concerning subject matter in which they are highly invested in advocacy goals.

h. The evidence indicates there is not a sufficient nor scientifically justified basis for abolishing the right of clients and professionals to engage in client-centred change-exploring talk therapies.

i. The proper scientific response to the currently limited knowledge base about SOCE would be to encourage further and ideologically diverse research rather than placing a broad and non-specific ban on professional practice. Such bans may well create unintended consequences for licensed

therapists who work with non-heterosexual clients and for the individuals who desire this therapy option.

j. There are practical difficulties with the MoU resulting from (1) attempted viewpoint control of therapists and clients, (2) failure to take into account scientific evidence that trauma may be a causal factor in same-sex attraction or behaviour, (3) failure to take into account individual differences in capacity for sexual attraction or behaviour change, (4) restricting clients' fundamental right to self-determination on the basis of scientifically unsupported claims of therapy harm, (4) serious lack of clarity in therapist guidance, and (5) failure to foresee unintended consequences.

k. There is a risk that the MoU does not have scientific grounds for drawing ethical conclusions.

III. ANALYSIS AND OPINIONS.

Note on competing worldview presuppositions.

7. The MoU crucially fails to comprehend the ideological dimension beneath its statements, the consequences of which become apparent when considering the influence of this political document. The acceptance and uncritical use of the MoU by the UK's Professional Standards Authority (PSA) for example, which appears to insist applicants for recognition of professional registers subscribe to, assumes anthropologic and epistemic commitments that are consistent with the general worldview of expressive individualism (Trueman, 2020).

8. In this underlying belief system authentic personhood is understood to reside in what one feels (one's inner experience, particularly sexual feelings in the present context). This overrides consideration of the body when these sources of information conflict. The truth of sexual and gender authenticity is determined by one's inner experience. Moreover, within expressive individualism one's authentic personhood needs to be expressed for it to be authentically lived. This assumptive framework regarding human authenticity naturally leads to the view that any attempts by a person to explore change of unwanted attractions or gender identities in counselling constitutes discrimination and an effort to eradicate a core component of that person's authentic self. Within this worldview, change toward heterosexuality or gender congruence and away from one's presumed authentic sexual and gender self is not deemed to be beneficial. Philosophically, this is why very few LGBT-identified persons pursue change as they consider their experience of sexuality and gender to be their authentic personhood. Those UK organisations which do not support or subscribe to the MoU such as the International Foundation for Therapeutic and Counselling Choice (IFTCC), do however acknowledge the rights of these LGBT-identified individuals to pursue counselling that is

consistent with their underlying worldview and to be free of any coercion in this pursuit.

9. However, the PSA is seriously deficient in overlooking the fact that not all sexual minorities have adopted a worldview characterised by expressive individualism. I have observed that sexual minorities who do not identify as LGBT are largely not so identified because of their traditional religious faith. Consistent with their traditional religious outlook, these individuals see the human body as a creation of God, with a design that has normative guidance for their sexual behaviour (Pearcey, 2018; Pope John Paul II, 1997). This physically based teleology is typically seen within a Judeo-Christian worldview as providing the best basis for guiding sexual expression, leading to human and societal flourishing. This means that for these sexual minorities, sexual attractions and behaviours that do not align with this teleological design of the body are viewed not as being innate but simply as characteristics of their sexual experience that do not define their identity. As such, these characteristics can be explored in counselling for their potential for change without this pursuit being experienced by these individuals as a threat to or violation of their authentic personhood. The truth of their sexual and gender authenticity is determined by their bodies as understood to be created and designed by God. Any counselling-assisted shifting of sexuality towards greater congruence with the design of the body would very much be experienced as a benefit by these sexual minorities. The PSA must acknowledge that other worldviews exist beyond their own, and that to coerce non-LGBT-identified sexual minorities into adopting a foreign assumptive framework for their counselling aspirations is, at heart, a form of ideological and cultural colonisation.

A. The Objectivity of the 2009 APA Task Force Report on SOCE Is Demonstrably Suspect; Therefore, the Report's Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE Is Neither Complete nor Definitive.

i. Bias in Task Force Selection.

10. Although many qualified conservative psychologists were nominated to serve on the task force that published the 2009 Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (the "Report"), all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defence: "*We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view"* (Carey, 2007). It appears that the APA operated with a litmus test when considering task force membership—the only views of homosexuality that were tolerated were those that uniformly endorsed same-

sex behaviour as a moral good. Thus, from the outset of the task force, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Report's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and has predictable consequences for how the task force addressed its work.

ii. Bias Regarding Statements of SOCE Harm and Efficacy.

11. This bias was particularly evident in the task force's highly uneven implementation of standards of scientific rigour in the utilisation and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Report dismisses most of the relevant research because of methodological limitations which are outlined in great detail (APA, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the task force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Report adopts very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Report uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that, *"...it has not been evaluated for safety and efficacy"* (APA, 2009, p. 91).

12. The six studies deemed by the task force to be sufficiently methodologically sound to merit the focus of the Report, targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of change-exploring talk therapies employs. This brings into question the Report's willingness to move beyond scientific agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Report seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change and; b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

13. There are places in the Report that seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Report states, “Thus, we cannot conclude how likely it is that harm will occur from SOCE” (APA, 2009, p. 42). Similarly, the Report observes, “Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective” (APA, 2009, p. 43). Similarly, “[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom” (APA, 2009, p. 83; cf. pp. 67, 120).

14. These expressions of agnosticism are justified by the task force but then are not adhered to in the Report’s conclusions. Instead, the Report argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Report does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the Report goes on to assert confidently that the success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the report, the potential for harm has morphed into “the potential to cause harm to *many* clients” (APA, 2012, p. 14, emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Report.

iii. Bias in Favour of Preferred Conclusions.

15. That the task force utilised a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes can be demonstrated by a few examples. The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions. First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed in the Report and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an even-handed methodological evaluation by the task force would not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There also was an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardised norms, the post hoc removal of tests that actually displayed

differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles.

16. As Hooker (1993) wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the task force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the *"overwhelming empirical evidence"* that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). Furthermore, the APA has cited Hooker's "*rigorous"* study in several of its amicus briefs (Schumm, 2014). The point here is not to argue for an association between homosexuality and pathology, but to underscore that a consistent application of the methodological standards affirmed in the Report should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

iv. Bias Regarding Treatment of the Primary Study on Harm.

17. Perhaps the most egregious example of the task force's methodological double standard is evidenced in their heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research in conclusions about harm from SOCE. Several methodological problems, of the sort the APA task force cited to dismiss the SOCE outcome literature, complicate these studies:

    a. These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: *"Homophobic therapies: Documenting the damage".*

    b. Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalisable sampling procedure.

    c. Only 20 participants in this study were women, creating significant skew toward gay male accounts.

    d. 25% of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.

    e. Finally, these subjects reported their experiences came from a mix of licensed therapists, non-licensed peer counsellors, and religious

counsellors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

f. The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades prior. The APA task force appears to have ignored the warnings from the study's authors: *"The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy"* (Shidlo & Schroeder, 2002, p. 250, emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from change-exploring talk therapies conducted by licensed medical and mental health professionals.

18. Again, what we can say with confidence is that some SOCE clients report harm and others report benefit and we do not know from the literature how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for censorship.

v. Bias Regarding the Lack of Context Concerning Harm in Psychotherapy.

19. The APA and other professional bodies that utilise this Report, and the signatories of the MoU and other organisations that censor SOCE, are negligent if not fraudulent in giving a warning that SOCE may potentially cause harm but failing to do so within the broader context that this warning certainly applies to all forms of psychological care for any and all forms of presenting problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative countertransference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

20. It should be noted in this regard that prior to the APA Report, no studies which provided prevalence estimates of harm from SOCE used a representative and population-based sample. The Report does not make this fact clear and has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame,

2013; Warren, Nelson, Burlingame, & Mondragon, 2012). In addition to psychotherapy deterioration rates, 40-60% of youth drop out of all forms of psychological treatment early (Kazdin, 1996; Nelson, et al. 2013; Wierzbicki & Perkarik, 1993).

21. These facts have considerable implications for contextualising the alleged reports of harm and efficacy from SOCE. Deterioration rates significantly beyond 20% would need to be established for professionally conducted SOCE in order for claims of approach-specific harms among youth or adults to be substantiated. Otherwise, MoU signatories are simply targeting one approach to psychological care on ideological and not scientific grounds.

22. Further, the high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved. This could result in a feeling of harm that would be attributable to the premature termination and not SOCE per se.

23. Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of medical and mental health difficulties *prior* to participating in any SOCE (Andersen & Blosnich, 2013; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; Friedman, Marshal, Guadamuz, Wei, Wong, Saewyc, & Stall, 2011; Kiekens, la Roi, & Dijkstra, 2021; Pakula, Shoveller, Ratner & Carpiano, 2016; Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded the commencement of SOCE. And since change-exploring talk therapies commonly involve helping clients become more aware of the stress and distress in their lives in order to manage or alleviate them, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre-) existing stress and distress. Thus, they may "feel worse" as a consequence of not having allowed therapy sufficient time to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high-quality research that might be able to distinguish such causation simply does not exist, as I will examine later in the declaration.

vi. Bias in the Omission of Medical Outcomes Associated with Same-Sex Behaviour.

24. It should also be mentioned in the discussions of harm and benefit from SOCE that the Report makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behaviour. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the U.S. but make up only an estimated 2-4% of men in the population (Newcomb &

Mustanski, 2011). This is occurring in a context where MSM are reporting higher rates of sexual risk behaviours in recent years in spite of increasing cultural acceptance. Similarly, the disparities in emotional distress, suicidal ideation, and suicide attempts between non-heterosexual and heterosexual persons have persisted since the 1990s and even appear to be getting worse for bisexual and lesbian girls (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Porta, Watson, Doull, Eisenberg, Grumdahl, & Saewyc, 2018). Certainly, whatever unclear risk of harm that might occur to an individual SOCE client must be weighed against the clear medical risks that arise from enacting homosexual behaviour, particularly salient among adolescents and youths. Yet the desire of the client to change attractions or even homosexual behaviour could jeopardise the standing of the therapist under the MoU.

vii. Bias Regarding Research on the Origins of Same-Sex Attractions.

25. Another example of the task force's uneven application of methodological standards concerns the Report's conclusion that, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the task force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalisable sample composed of psychiatric patients. All of these problems were considered to be fatal flaws in the task force's appraisal of the SOCE outcome literature for documenting evidence of change but were ignored for conclusions that the task force wanted to draw.

26. Given that many of the methodological limitations used by the task force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the task force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically flawed that one cannot make any conclusive statements concerning the applicability of

developmental factors in the origin of homosexuality. Thus, by the task force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

27. If such ambiguity exists in the SOCE literature on methodological grounds, then by the task force's own criteria, this ambiguity also is present in the referenced aetiological research. The task force members have been inconsistent in the application of their methodological critique to the broader literature on homosexuality and they have been willing to offer more definitive conclusions about theories they wish to dismiss than is warranted by their own standards. In a word, there is again the appearance of substantial bias.

28. Contra to the repeated claims of the Report that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exist recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008, Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the aetiology of same-sex attractions, some studies that existed prior to the Report were ignored by the task force. Moreover, the 2014 APA Handbook of Sexuality and Psychology underscored the need for research to explore the "associative or potentially causal links" between a same-sex orientation and childhood sexual abuse (Mustanski, Kuper, & Green, 2014).

29. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviours who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse. Prohibiting them from receiving much needed professional care that treats underlying trauma and its link to their unwanted same-sex attraction or behaviour may be unethical.

30. This is underscored by the much higher prevalence rates of childhood sexual abuse (CSA) among non-heterosexuals (Andersen & Blosnich, 2013; Outlaw et al., 2011; Sweet & Wells, 2012; Tobin & Delaney, 2019; Xu & Zheng, 2015) and the fact that men experience more distress when sexually assaulted by a man as opposed to a woman (Artime, McCallum, & Peterson, 2014). Across relevant studies, median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman, Exner, & Baughman, 2011). Furthermore, as Xu and Zheng observe, "It is possible that CSA causes an

individual to develop a same-sex sexual attraction" (p. 328). The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors beyond physical, sexual, and emotional abuse. Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013). These researchers favour the view that attachment insecurity plays a causal role in gender atypicality, though they acknowledge that longitudinal studies are needed to confirm their suspicions. Andersen and Blosnich (2013) reported higher levels of exposure to adverse childhood factors (e.g., mentally ill, substance-abusing, or incarcerated family members) for non-heterosexuals that were not likely to be the result of the child's nascent homosexuality, as is sometimes alleged as an explanation for elevated rates of physical and sexual abuse. The authors disagree but acknowledge that, "Some researchers posit that childhood adversity (particularly sexual abuse) may play a causal role in the development of same-sex preferences or sexual minority identity" (p. 5).

31. One example of this is research suggesting a causal role for childhood sexual abuse in the development of same-sexual orientation is based on a developmental and conditioning paradigm (Beard et al. 2013; Bickham et al. 2007; Hoffman, 2012; O'Keefe et al. 2014). For example, O'Keefe et al. (2014) and Beard et al. (2013) studied the effects of brother-brother incest and sister-brother incest in a sample of 1,178 men. They concluded that, "The origins of this increased interest in sex and the origins of bisexual or same-sex sexual orientations as well as the origins of many of the powerful urges to engage in behaviours such as exhibitionism or to use objects sexually can be explained as arising from early childhood experiences through the synergistic actions of critical period learning, sexual imprinting, and conditioning" (O'Keefe, et al., 2013, p. 27). These researchers also observed that such processes could account for much of the data that has been utilised to suggest a dominant biological or genetic explanation for non-heterosexuality.

viii. Bias Regarding Use of the "Grey Literature".

32. The uneven methodological implementation of standards is again seen in the Report's treatment of the "grey literature," which is dismissed in favour of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly, prospective, longitudinal study on SOCE supportive of change for some individuals and finding no harm on average and significantly improving psychological symptoms is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on page 90 of the Report; see also Jones & Yarhouse, 2011). Yet the task force appears to have no compunction in citing the grey

literature on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilises a sample of questionable representativeness.

ix. Bias in the APA's Broader Treatment of Sexual Orientation.

33. A final differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. An analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the task force applied to the SOCE literature. The Marks study concluded that, "...some same-sex parenting researchers seem to have contended for an 'exceptionally clear 'verdict of 'no difference 'between same-sex and heterosexual parents since 1992". However, a closer examination leads to the conclusion that strong, generalised assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, 'the line between science and advocacy appears blurred'" (p. 748).

34. While Marks 'analysis does not focus on change-exploring talk therapies, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in policy conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is what appears to have occurred when the signatories of the original MoU relied on the APA task force Report.

x. The APA Report Is Not Definitive Regarding the Risk of Harm from SOCE Due to Its Scientific Shortcomings and Pervasive Bias, and This Undermines All Position Statements Based on It.

35. In addition to the pervasive bias demonstrated above, two fatal scientific flaws in the APA Report and all subsequent studies, resolutions, and position statements based on it are their (1) inability to account for pre-SOCE levels of distress and (2) the general exclusion from studies of non-LGBT-identified sexual minorities. Statistically controlling for pre-SOCE exposure levels of distress is a key component for disentangling distress attributable to a psychotherapeutic intervention and distress experienced by clients prior to ever engaging in therapy. Without this data, the actual degree of harm attributable to therapy is unknowable. This is a critical fact of basic research methodology, particularly when the population under study is known to have high levels of adverse childhood experiences. To cite only one example, non-heterosexual persons report much higher levels of childhood sexual abuse (CSA) than heterosexual persons (Friedman et al., 2011; Rothman et al., 2011:

Xu & Zheng, 2015), and CSA has been linked to later suicidality (Bebbington, et al., 2009; Bedi et al., 2011; Eskin, Kaynak- Demir, & Demir, 2005; Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016). Hence, without pre-SOCE assessment of participants' suicidality, claims attributing frequent suicidal thoughts and behaviours to be the direct result of change-exploring talk therapies constitute empirically unfounded speculation.

36. The critical importance of controlling for pre-SOCE exposure levels of suicidality and distress has recently been dramatically demonstrated. A study by Blosnich et al. (2020) utilised a nationally representative dataset (the Generations survey) developed and compiled by the LGBT+-allied Williams Institute at UCLA and made available to other scholars. Oddly, Blosnich and colleagues did not take into account data concerning the subjects' pre-SOCE distress in his study design even though such information was available in their dataset. These researchers nevertheless purported to find that "SOCE" had "insidious associations with suicide risk" and "may compound or create…suicidal ideation and suicide attempts." I will note that "insidious associations" is a rhetorical rather than a scientific statement, while "may compound or create" describes a hypothesis that should be tested, not a scientific finding.

37. More recently, Professor Donald Sullins has performed a reanalysis of the original study of Blosnich et al., but took into account the pre-"SOCE" distress levels of the study subjects (Sullins, 2022). Sullins reanalysis discovered a very different reality. While the effect of controlling for pre-SOCE suicidality was larger for adults than for minors, Sullins reported:

> After accounting for pre-existing suicidal behaviour, sexual minorities who underwent SOCE treatment were not at higher risk of suicidality. Indeed, some of them may have been placed at much lower suicidal risk. Judicial or legislative restrictions on SOCE participation could deprive sexual minorities of an effective resource for reducing suicidality, thereby putting them at substantially higher suicide risk. (p. 3390).

38. It is possible that Sullins' findings understate the beneficial effect of change efforts, since those who may have attained the goal of SOCE—to adopt heterosexual identity, orientation, or sexual function—were systematically screened from the survey sample, which only included those currently identifying as a sexual minority.

39. Finally, Sullins observers that the most recent APA resolution on SOCE (APA, 2021a), a recent volume, *The case against conversion therapy*, published by the APA (Haldeman, 2022; see particularly the chapter by Glassgold, 2022), and the 2021 review of SOCE research by a team scholars commissioned by

the British National Equalities office (Jowett et al., 2021), all rely significantly on the Blosnich et al. (2020) study to confidently assert the SOCE-suicide connection. Sullins points out the serious negligence involved in the uncritical use of Blosnich et al.:

> "The consequences of flawed inference are not merely theoretical, however. By ignoring time order, Blosnich et al. (2020) have mistakenly attributed causation to what may be, in part, a cure of suicidal distress, with potentially harmful consequences for sexual minority persons. Imagine a study that finds that most persons using anti-hypertension medication have also previously had high blood pressure, thereby concluding that persons 'exposed' to high blood pressure medication were much more likely to experience hypertension, and recommending that high blood pressure medications therefore be banned. This imagined study would have used the same flawed logic as Blosnich et al.'s (2020) study, with invidious consequences for persons suffering from hypertension." (p. 3390)
>
> Sullins' reanalysis of Blosnich et al. by controlling for pre-SOCE distress is of great importance because every other recent study critical of SOCE (e.g., Fenaughty et al., 2023; Green et al., 2020; Flentje et al., 2013; UK Government Equalities Office, 2018; Meanley et al., 2020; Ozanne Foundation Advisory Board, 2018; Ryan et al., 2018; Salway et al., 2020) suffers from the same oversight (see Rosik, 2023, for a more expansive list). Hence, this literature is insufficient to support any putative harm-based prohibition of speech-based therapies that work with a client's goal of exploring their sexual attraction fluidity potential.

40. Recent statements and resolutions by the APA have taken an even more hostile tone toward SOCE (APA, 2021a, 2021b) and have lost any pretence to a measured objectivity, preferring talk-therapy bans to conducting further and ideologically diverse research. The APA's 2021 Resolution does not point to any more recent research that would change the conclusion of their 2009 Report that the current research is insufficient to draw any definitive conclusions. The newer studies the 2021 Resolution cites have serious methodological flaws, and, in some cases, do not even support its conclusions, as noted above. I have outlined these primary limitations in a recent publication, which will be attached to this report available in the "Supportive Documents for Rosik & Haynes Reports" on this website. To give just one example here, on page 2, the 2021 Resolution says that the "APA is particularly concerned about the significant risk of harm to minors from SOCE." (APA, 2021a, p.2). Yet neither of the two reports it cites are research at all, much less establish harm from SOCE. The first (Hatzenbuehler & Pachankis, 2016) is a review article of theoretical and clinical reports, and the

second (Robinson, 2017), which discusses black LGTBQ youth in detention, acknowledges that there is little research on this population and knowledge about it "is speculative." (Robinson, 2017, p. 12). The APA 2009 Task Force Report, and especially its 2021 Resolution, characterise the pursuit of SOCE primarily as a consequence of social stigma and prejudice, which I will address below. This is a very low view of human agency. There is a striking lack of acknowledgement that sexual minority persons with traditional faiths can and do freely choose to explore change, often with a goal of honouring a faith they find brings them meaning and happiness (Barringer & Gay, 2017). Legally foreclosing the option to pursue such goals in a strictly speech-based psychotherapy can be seen as a form of religious bigotry.

41. As noted above, however, the APA's pronouncements about SOCE are blind to the issues Sullins has exposed for all to see, not to mention many other theoretical, logical, and scientific flaws (Phelan et al., 2022). The failure to account for pre-SOCE distress is not occurring because the APA or its experts are unaware of the need for such statistical controls. In fact, the APA's Resolution related to abortion (APA, 2022) specifically makes such an argument to discount research concerning potential harms from this procedure: "The research points out design flaws in studies that cite mental health risks because they did not account for prior mental health diagnosis." Yet nowhere in the APA's 2021 Resolution is such an important research consideration offered as pertains to the "design flaws" of all the SOCE research. This contrast clearly betrays an inability and/or unwillingness on the part of the APA to be even-handed in their appraisal of research that favours their preferred narrative, i.e., that SOCE invariably cause harm.

42. The fact that recent APA guidelines and resolutions cite the Blosnich et al. (2020) study as support for the contention that SOCE elevates the risk of suicide suggests the presence of confirmation bias (i.e., the propensity for scholars to be more critical of research they disagree with than with research whose conclusions confirm their preexisting beliefs). This can be how capable scholars embedded in ideological monocultures fail to consider a monumental flaw in SOCE research that appears to fundamentally alter the SOCE-suicide narrative, indicating a relationship that is either non-existent or the opposite of what they are so confident is true.

43. Sullins' reanalysis has spurred a productive debate on this topic (Blosnich et al., 2023; Glassgold & Haldeman, 2023; Rivera & Beach, 2022), to which Sullins has responded to in detail (Sullins, 2023), resulting in further analyses which he believes only strengthen the findings of his initial reanalysis.

> "The conclusions of Blosnich et al. (2020) regarding the invidious harm of SOCE remain in the realm of contrived illusion, not observed reality,

> produced by their failure to apply the principle of causal time order, i.e., that a result cannon reasonably be attributed to a cause later in time." (p. 4)

Sullins concludes his rejoinder by asserting the role of organised psychology (and, by extension, national governments) is to inform the profession and the public, not legislate against an individual's right to self-determination.

> "For the same reasons that same-sex orientation should not be coercively changed, they should not be coercively prohibited from change. If it is true for heteronormative advocates, then it is equally true for sexual minority advocates, that love is love, and persons who love in ways with which they vehemently disagree should be permitted to live their lives in peace and dignity, without distraction or discrimination. It is a perverse from of bigotry that insists that tolerance of adopting a same-sex orientation requires intolerance of adopting a heterosexual orientation." (p. 5)

44. A second critical flaw in the SOCE literature and the APA statements and resolutions based on it concerns the fact that research in this literature has largely been dominated by the utilisation of samples exclusively made up of those who self-identify as LGBT. But recent research suggests a significant subpopulation of sexual minorities (including those who experience opposite-sex attractions) choose not to be defined by those attractions, and so do not identify themselves as LGBT if asked, and are unlikely to be found in the LGBT-identified networks and venues often utilised by researchers for participant recruitment (Lefevor et al., 2020; Rosik et al., 2021). These individuals tend to be more traditionally religious, more active in their religion, less engaged in same-sex behaviour regardless of experienced attractions, and more interested in a child- and family-centred life. To generalise from LGBT-identified sexual minorities to those who do not so identify is to commit a serious methodological error.

45. This characteristic of SOCE consumers to not be LGBT-identified was noted a generation ago by Shidlo and Schroeder (2002), but has seemingly been ignored by modern SOCE researchers and the APA. Shidlo and Schroeder commented, "…on the basis of the conversion therapy literature and our own empirical research, we have found that conversion therapists and many clients of conversion therapy steadfastly reject the use of lesbian and gay. Therefore, to have used gay-affirmative words would have been inaccurate and unfaithful to their views." (p. 249)

46. Thus, given the widespread recognition that most individuals who seek counselling to assist in reducing same-sex attractions are motivated by goals,

morality, and a conception of self that are shaped by religious conviction (APA, 2009; Shidlo & Schroeder, 2002; Rosik et al., 2021a; Sullins et al., 2021), it appears studies that recruit subjects exclusively within the self-identifying LGBTQ community or define the sexual minority population only by an LGBT identification are excluding a large number of those who seek out and participate in voluntary counselling with the goal of reducing same-sex attractions or behaviours. Rosik (2022) has documented that most if not all recent SOCE-critical studies have samples consisting exclusively of or overwhelmingly dominated by participants that are, in fact, LGBT-identified. *There is no reason to assume the SOCE experiences and responses of sexual minorities not LGBT identified mirror the experiences of sexual minorities who identify as LGBT+.* On the contrary, it would be reasonable to hypothesise that such counselling is likely to be more effective for, and appreciated by, precisely by those who do not consider their experience of sexual attractions to be the central organising principle of their self-definition (for recent studies suggesting just such a divergence between LGBT+-identified and non-LGBT+-identified sexual minorities, see Rosik et al., 2021b, 2022 below).

47. To illustrate the reality of this problem, a recent meta-analysis found no relationship between religiousness/spirituality and health among studies based on sexual minority samples from LGB venues, but a significant and positive relationship when sexual minority study participants were *not* recruited through LGB venues (Lefevor et al., 2022).

48. A recent study of 125 highly religious men reported 42.7% of these men perceived SOCE to help them achieve at least partial remission of unwanted same-sex sexuality (Sullins et al., 2021). A large majority of participants reported SOCE to be associated with enhanced psychological well-being, while only 1 in 20 reported any negative effects. The authors noted the studies purporting SOCE harms and commented: “The occurrence of such discrepant findings regarding SOCE exposure deserves a more plausible explanation than that of the universal self-deception or falsification of SOCE benefits among sexual minorities who report them…In light of this need, we propose a plausible explanation to harmonise this literature: *Researchers are studying very different subpopulations of sexual minorities, distinguished in large part by their different experiences of contemporary, speech-based forms of SOCE, which should not be generalised to all sexual minorities*.” (p. 13, authors’ emphasis)

> The exclusion of sexual minorities who are not LGBT-identified from the research is another reason any generalisation of harm from the recent studies to the counselling experiences of individuals who do not self-identify as LGBTQ is a scientifically improper practice. This exclusion is critical inasmuch as self-report information can be subject to distortion and

bias. As the APA Task Force report (APA, 2009) noted, "People find it difficult to recall and report accurately on feelings, behaviours, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall." (p. 29) By utilising samples whose participants come from diverse religious and socio-political outlooks, not just those who identify as LGBT, the impact of advocacy motivated and/or inaccurately remembered accounts can be significantly mitigated.

49. To summarise, a proper conclusion regarding the 2009 APA Report and its progeny is that these reports, position statements, and resolutions cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and therapists to provide change-exploring professional psychotherapy. Utilising this research to evaluate the provision of change-exploring talk therapies makes no more sense than studying a sample of former marital therapy patients who have subsequently divorced to determine the effectiveness and harm of marital therapy in general.

B. Non-heterosexual Identities, Attractions, and Behaviours Are Subject to Change for Many People and Particularly Among Females and Youth.

50. Central to the notion that some individuals can and do report change on a continuum of change in their sexual orientation is the issue of *immutability*. The APA Task Force Report said one of the "key findings in the research" on which it based its conclusion was that sexual orientation does not change through life events (APA, 2009, pp. 63, 86). Were all same-sex attractions and behaviours fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise for minors or adults. However, there is solid data to suggest that same-sex attractions and behaviours are not fixed and are subject to varying degrees of change. As summarised by Ott et al. (2013), "Reported sexual identity, attraction, and behaviour have been shown to change substantially across adolescence and young adulthood" (p. 466). Hu, Xu, and Tornello (2016) studied longitudinal data and observed, "In the LGB [lesbian, gay, and bisexual] population, the dominant pattern was change." Dickson, van Roode, Cameron, and Paul (2013) further asserted that, "People with changing sexual attractions may be reassured to know that these are common rather than atypical (p. 762)." This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "...the importance of viewing sexual orientation as a process which often changes over time" and noted "...the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

i. Lack of Agreement Regarding What Constitutes Sexual Orientation.

51. Contrary to conventional wisdom, there is substantial debate within scientific circles as to what constitutes "sexual orientation", and this uncertainty extends to terms such as "sexual orientation change efforts." Sexual orientation may be said to comprise same-sex attractions, fantasies, and behaviours, but this is insufficient to guide change-exploring talk therapists in knowing clearly whether what they are discussing with a client could be considered as a *sexual orientation* change effort. That term is nebulous, and many scholars admit they have no precise means of distinguishing sexual orientation from same-sex sexuality, *i.e.*, same-sex behaviours and attractions that may not signify a same-sex orientation (Diamond, 2003). Relatedly, Savin-Williams (2016) described sexual orientation as being a continuum rather than discreet categories, which theoretically could mean that an isolated same-sex attraction for an otherwise completely heterosexual person might be considered as a separate sexual orientation.

52. Echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorisation altogether, at least within the realm of social scientific research" (p. 125). Finally, Diamond and Rosky (2016) acknowledged these problems when they indicated,

> "....it is important to note that sexual orientation is not easy to define or measure. This obviously poses a problem for research on the causes of sexual orientation, given that the first step in such research is to identify individuals with different sexual orientations." (p. 365).

53. One could rationally argue that this also poses a problem for professional organisation censorship of change-exploring therapy, in that sexual orientation must be defined in order to communicate exactly what is being censored and with what justification.

54. It is clear that, contrary to how the term "sexual orientation" is utilised in political circles, scholars and researchers in the know have acknowledged for some that it is difficult to pinpoint exactly what "sexual orientation" means. In actuality, what constitutes sexual orientation and gender are often fluid experiences that are impossible to define in any static manner, such as the MoU assumes. Some examples of this acknowledgement include the following:

    a. "…there is no agreed-upon definition or measurement of sexual orientation. Whether sexual orientation is a categorical construct or exists on a continuum is still debated. The central components or dimensions of sexual orientation are likewise an unresolved matter." (p. 180) Kinnish, K. K., Strassberg, D. S., & Turner, C. W. (2005).

b. “Chief methodological challenges include the need to develop analytic approaches that have the capacity to characterise and analyse sexual orientation while accounting for both time-variance in important dimensions of sexual orientation, such as identity, attractions, and sex of sexual partners, and possible time-varying effects on health, adjustment, and other outcomes” (p. 519) Ott, M., Corliss, H., Wypij, D., Rosario, M., Austin, B. (2011).

c. “To quantify or count something requires unambiguous definition of the phenomenon in question. And we lack this in speaking of homosexuality.” (p. 290)

d. “Development of self-identification as homosexual or gay is a psychologically and socially complex state, something which, in this society, is achieved only over time, often with considerable personal struggle and self-doubt, not to mention social discomfort. All these motives, attractions, identifications, and behaviours vary over time and circumstances with respect to one another—that is, are dynamically changing features of an individual’s sexual expression.” (p.291) Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994).

e. “In light of such findings, one might argue for an end to sexual categorisation altogether, at least within the realm of social scientific research” (p. 125). Diamond, L. M. (2005).

f. “The instability of same-sex attraction and behaviour (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals” (p. 393). Savin-Williams, R. C., & Ream, G. L. (2007).

55. What this means on a practical and clinical level is that the therapist is left to sheer speculation regarding when they are dealing with sexual orientation in violation of the MoU and when they are not. For example, if a person experiences same-sex attraction 10% of the time (i.e., a “mostly heterosexual” designation) is the person gay or bisexual or heterosexual, particularly if they identify as heterosexual (which the vast majority do). Does this change if a person reports same-sex attractions 15% of the time? At what point in such people’s experiences do their same-sex attractions transform from being a characteristic they have and may seek to change into a sexual orientation that they must be legally prohibited from exploring their potential for change?

56. Must the individual with 10% same-sex attractions be prohibited from the opportunity to explore the potential for reducing these attractions and associated behaviours even when they desire to strengthen their heterosexual marriage? If what actually is denoted by the constructs of sexual orientation and gender are moving targets with permeable and ill-defined boundaries for scholars, how much more is the average therapist and counsellor left to rely on complete guesswork to know if they are in violation of the MoU dictates? In light of these considerations, any legal prohibition on counselling a person seeking to explore change must be exceedingly precise with regards to the qualitative and quantitative aspects of same-sex sexuality and gender identity that constitute the sexual orientations and gender identities they are wanting to protect. Not to provide this guidance is to concede that authors of the MoU in reality have no sufficiently clear idea what they are really referring to when they use such terms.

ii. Non-Heterosexuality Is Not a Fixed Trait.

57. The definitive study by Laumann, Gagnon et al. (1994), cited by the APA (2009) task force, involved several thousand American adults between the ages of 18 and 60. This report contains the most careful and extensive database ever obtained in the U.S. on the childhood experiences of matched homosexual and heterosexual populations. One of the major findings of the Laumann, Gagnon et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely seemed to exist (Laumann, Michael, and Gagnon, 1994). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report:

> "...this implies that almost 4% of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterwards, constitute 42% of the total number of men who report ever having a same-gender experience." (Laumann, Gagnon, et al., p. 296)

58. They also note that their findings comport well with other large-scale studies.

> "[O]verall we find our results remarkably similar to those from other surveys of sexual behaviour that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys...one in France [20,055 adults] and one in Britain [18,876 persons]." (p. 297)

59. These data suggest that heterosexuality is normative even for those who at one point in the past reported a non-heterosexual sexual orientation. Further research has found that sexual orientation stability appears to be greatest

among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among non-heterosexual individuals" (p. 104). Moch & Eiback (2010) found that heterosexuality was more stable than homosexuality or bisexuality over a 10-year period in middle-aged adults. Nearly half of women with initial bi- or homosexual identity opted for a different label 10 years later. Diamond and Rosky summarise the matter well: "Given the consistency of these findings, it is no longer scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait" (p. 370).

60. Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e., heterosexual. Therefore, it is not surprising that the brain would self-organise behaviour in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

61. Whether measured by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life occurred largely in one direction—toward heterosexuality—and reflected a significant decline in non-heterosexual identities. This evidence of spontaneous change with the progression of time among both males and females does not go with a notion that sexual same-sex attraction or behaviour cannot safely change. To be fair, we cannot tell from this data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that change-exploring talk therapies could aid some minors and adults in modifying same-sex attractions and behaviour. It appears that the most common natural course for a young person who develops a non-heterosexual sexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies disallowing the potential for change (e.g., "gay-affirmative") could be interfering with normal sexual development.

iii. Fluidity of Non-Heterosexual Sexual Attractions and Identity is Commonplace.

62. Diamond's longitudinal studies of women with non-heterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "Hence, identity *change* is more common than identity *stability*, directly contrary to conventional

wisdom" (italics in original, p. 13). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "...demonstrate considerable fluidity in bisexual, unlabelled, and lesbian women's attractions, behaviours, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12).

63. Farr, Diamond, and Boker (2014) presented evidence for the existence of subtypes of non-heterosexual women, both in the intensity or degree of their same-sex attractions and in how these attractions change over time. She noted that these women appear more likely than men to specifically report the roles of circumstance, chance, and choice in their sexual identity and orientation, concluding that, "These results support the notion that some degree of plasticity may be a fundamental component of female same-sex sexuality" (p. 1487). Dickson et al. (2013) reviewed the relevant scientific literature and concluded, "These studies demonstrate that there is more change in sexual orientation than would be expected from repeated cross-sectional studies and change appears to be more common among women than men" (p. 754).

64. Clearly, change in sexual attractions and behaviours on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted change-exploring talk therapies as one option for minor girls or women experiencing unwanted same-sex attractions and behaviours, provided adequate assessment to ensure voluntary and informed consent. Finally, echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorisation altogether, at least within the realm of social scientific research" (p. 125).

65. Although the general scholarly consensus is that non-heterosexual women are more fluid in their sexual attractions and behaviours than men, this may not be the case. As Diamond (2017) noted, "Female sexuality was once thought to be more fluid and plastic than men's, but recent research has begun to challenge this view" (p. 1184). This includes research on sexual orientation fluidity by Katz-Wise (2015) and Katz-Wise & Hyde (2015). These researchers studied a sample of young adults (18-26 years of age) who reported a same-gender sexual orientation. They discovered that 63% of the women and 50% of the men reported fluidity in their sexual attractions, and of these individuals 48% of the women and 34% of the men also reported change in their sexual orientation identity. Of additional import for evaluating the legitimacy of MoU therapy censorship, especially regarding minors, participants who reported fluidity indicated that their initial experience of change in sexual attractions occurred on average *before* the age of 18.

66. More recently, Diamond (2016) reviewed relevant studies and concluded,

> "The other major conclusion that we can draw from these studies is that change in patterns of same-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented...between 25% and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon." (p. 253)

67. It is also noteworthy that the Katz-Wise studies reported sexually fluid participants were more likely than sexually non-fluid participants to believe that sexual orientation is changeable. Non-sexually fluid men were more likely than sexually fluid men to believe that sexuality is something an individual is born with, while men who reported experiencing sexual fluidity were more likely than men who did not report sexual fluidity to view sexuality as changeable and subject to environmental influences. These findings may help explain the overwhelming dominance of men who provide testimony and personal anecdotes in favour of SOCE bans, suggesting that non-heterosexual men who have not experienced change may assume that this is the case for all non-heterosexuals and support laws that ban professional change-exploring talk therapies for even sexually fluid male youths who freely seek assistance with their pursuit of change.

68. In its 2021 Resolution on sexual orientation change efforts, even the APA openly acknowledges that "sexual orientation can evolve and change for some," and that there is "evidence of sexual fluidity across the lifespan." (APA, 2021a). The 2021 Resolution immediately caveats that "this does not mean that it can be altered through intervention or that it is advisable to try." This is not based on any new or non-partisan appraisal of the evidence of the effectiveness of sexual orientation change efforts, which is no more definitive than it was in 2009 when the APA Report was published, but is best understood to represent an advocacy position of one socio-politically dominant subset of the field.

iv. Change Among Transgendered/Transsexual Individuals.

69. Intriguing research among transgendered persons finds that these individuals often report a change in their sexual orientation (Auer, Fuss, Hohne, Stalla, & Sievers, 2014). These researchers found almost 21% of their sample of 115 transsexual participants reported experiencing a change in their sexual orientation. They noted that, "Transition [surgically from one sex to the other] was not directly involved in this change, since a significant number of

participants reported a change in sexual orientation prior to first psychological counselling and prior to initiation of cross-sex hormone treatment. The participants provided diverse individual explanation models, revealing that personal history, social environment as well as autoerotic feelings may impact on a change in sexual orientation" (p. 11). They observed that these changes may even be affected by personal decisions, quoting one participant as stating, "While some people think that gender identity is something you acquire or learn, I think this was rather true for my alleged sexual orientation" (p. 9). While this study may raise more questions than it ultimately answers, it further undercuts an understanding of sexual orientation as a stable self-construct that is unchangeable for all persons in all circumstances.

v. Pursuing Change in Same-Sex Sexual Behaviour is Permissible and Welcomed in Other Contexts

70. Well-received studies have been published on voluntary, talk-based therapy pursued by gay and bisexual men with the treatment goal of suppressing or decreasing casual same-sex behaviour to reduce HIV transmission risk. These studies reported success in decreasing same-sex behaviour over an extended period of time (Nyamathi et al., 2017; Shoptaw et al., 2005; Shoptaw et al., 2008; Reback & Shoptaw, 2014). This research utilised replicated, randomised control trials examining mainstream therapies, culturally adapted mainstream therapy, and lay peer counselling to achieve significant decreases in casual same-sex behaviour, maintaining these gains at 6 to 12-month follow-ups. The goal behind these studies was to reduce HIV transmission among this population, but the success of these studies contradicts the hypothesis that counselling with a goal of reducing same-sex behaviour is necessarily ineffective. In addition, none of these studies reported adverse effects from the counselling on the mental health of the subjects. Both the MoU and the APA Resolution appear to ban not only attraction change but also behavioural change toward heterosexuality. The appearance this gives is one where these entities intend to prohibit therapy to decrease sexual partners only if the partners are of the same sex.

vi. Change Not Limited to Sexual Behaviour.

71. A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behaviour* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of

environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to take place in the years prior to 21 in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumes. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

72. More recently, similar findings were reported among a sample of 116 polyamorous and mono-amorous individuals (Manley, Diamond, & van Anders, 2015). The authors suggest "the prevalence of attraction shifts contradicts notions of attraction as stable and partnering behaviours and sexual identities as more fluid. Attraction shifts were far more common than shifts in either sexual identity or partner gender" (p. 177).

vii. Change Particularly Evident for Youth, Bisexuals, and Women.

73. Change in sexual attraction and behaviour has been shown to be particularly substantial for youth (Ott et al., 2013; Katz, 2015; Katz-Wise and Hyde, 2015), bisexuals (Savin-Williams, Rieger, & Joyner, 2012; Hu, Xu, and Tornello, 2016; Moch & Eiback, 2010; Diamond, 2005, 2008; Diamond & Rosky, 2016, p. 253), and women (Katz, 2015; Katz-Wise and Hyde, 2015; Savin-Williams, Rieger, & Joyner, 2012; Diamond, 2005, 2008; Diamond & Rosky, 2016). The MoU does not discriminate in its prohibition between SOCE provided for exclusively same-sex attracted individuals and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the MoU's censorship distinguish between minors and adults. In fact, these studies suggest it is irresponsible to prevent access to change-exploring talk therapies and only allow affirmation of same-sex feelings, especially for women and minors, on the supposed grounds that the feelings are intrinsic, unchangeable, and therefore the individual can only be homosexual.

74. MoU's intent for a blanket prohibition on SOCE for all minors or adults with unwanted same-sex attractions and behaviours is akin to doing heart surgery with a chainsaw in its inability to address the complex realities of sexual orientation. For example, a study by Herek et al. (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not

inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviours could occur in change-exploring talk therapies for some individuals who voluntarily desire and seek such change. Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or a great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other research confirms the particular instability of a bisexual sexual orientation (Savin-Williams, Joyner, & Rieger, 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of therapy censorship. At a minimum, such data suggest that proponents of the MoU would have done better to exclude bisexuality from the scope of this censorship. With the statistical analysis indicating that a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, it is conceivable that change-exploring talk therapies might augment this process for some individuals with unwanted same-sex attractions and behaviours.

viii. Identification of the Mostly Heterosexual Orientation.

75. Further evidence that the MoU ignores distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2-3% of men and 10-16% of women over time and constitutes a sexual orientation larger than all other non-heterosexual identities combined (Savin-Williams, Joyner, & Rieger, 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other non-heterosexual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by physiological evidence in a sample of men (Savin-Williams, Rieger, & Rosenthal, 2013). This apparently viable and unique group of non-heterosexuals raises serious questions for the scope of the MoU; namely, whether "mostly heterosexual" minors and adults are exempt from the MoU's ban on SOCE. The fact that the MoU appears to be unaware of important nuances highlights the difficulty of the MoU's attempting to adjudicate the complex scientific matters surrounding change-exploring talk therapies.

76. All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and maybe more so for youth, women, and bisexuals) and that this change is best conceptualised as occurring on a continuum and not as an all-or-nothing experience. The experience of clinicians who engage in change-exploring talk therapies is that while some clients report complete

change, and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behaviour and sexual orientation identity.

77. Descriptions of licensed therapists engaged in SOCE as trying to "cure" their clients of homosexuality are at best ignorant of how these therapists conceptualise their care (see Alliance for Therapeutic Choice and Scientific Integrity (ATSCI, 2018)). Licensed therapists who provide change-exploring care recognise that change of sexual orientation typically occurs on a continuum of change, and this is consistent with how change is understood to occur for most if not all other psychological and behavioural conditions addressed in psychotherapy.

C. Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

78. Moreover, such fluidity and change make clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviours is not determined at birth and there is no convincing evidence that biology is determinative for many if not most individuals (Diamond & Rosky, 2016). The American Psychiatric Association has observed that, "...to date, there are no replicated scientific studies supporting any specific biological aetiology for homosexuality" (American Psychiatric Association, 2013). Peplau et al. (1999) earlier summarised, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation...Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation."

79. It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008a; emphases added).

80. Yet the APA has made minimal effort to publicise the change in its official position on such causation or to correct the accompanying popular misconception – often promoted by the media – that persons with same-sex attractions are simply "born that way" and "can't change."

81. The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large-scale studies of identical twins. These studies indicate that if one twin sibling has a non-heterosexual orientation the other sibling shares this orientation only about 11% of the time with upper estimates at 24% (Bailey, Dunne, & Martin, 2000; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Xu, Norton, & Rahman, 2019). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence in the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses. Xu and colleagues (2019) concluded, "Thus, most of the differences between people in their sexual orientation are due to environmental factors (often nonshared) pointing to multiple aetiology" (p. 1).

82. Similarly, heritability of sexual orientation is approximately .32, indicating that 32% of the population variability in sexual orientation is due to genetic factors (Diamond & Rosky, 2016). Heritability is the variability between persons in a population, not an indicator of the relative contributions of genetic and environmental influences within individuals. Diamond and Rosky put this in perspective by stating, "...it is helpful to note that higher estimations of heritability (ranging from .4 to .6) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction" (p. 366). Given these statistics, it is curious that, for example, smoking is a behaviour considered subject to change, while proponents of SOCE bans often maintain sexual orientation is an immutable behavioural characteristic.

83. The inaccuracy of a strictly genetic understanding of same-sex sexuality was definitively supported in a 2019 large-scale study by a team of authors from Harvard, MIT, and several other prestigious institutions (Ganna et al., 2019). These researchers analysed the genomes of almost half a million individuals, along with self-reported information about heterosexual and same-sex sexual behaviours. They found that genetic variants accounted for only 8-25% of the variation in male and female same-sex behaviour, with similar patterns for same-sex attractions and identity. There were only "very small" correlations between any genes and same-sex behaviour. The authors concluded:

> "We established that the underlying genetic architecture is highly complex: there is certainly no single genetic determinant (sometimes referred to as the 'gay gene' in the media). Rather, many loci with individually small effects spread across the whole genome and partly overlapping in females and males, additively contribute to individual differences in predisposition to same-sex sexual behaviour. All measured common variants together explain only a part of the genetic heritability at the population level and do not allow meaningful prediction of an individual's sexual preference." (p. 6)

84. These researchers also noted their findings "…point to the importance of sociocultural context as well" (p. 6). They observed that the prevalence of same-sex sexual behaviour was subject to changes across time and conjectured that differences in genetic influences between males and females could reflect differences in sociocultural contexts between male and female same-sex behaviour as well as different demographics of gay, lesbian, and bisexual groups.

85. Causatively then, sexual orientation is by no means comparable to a characteristic such as eye colour or biological sex, which are thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices such as those which might be facilitated in change-exploring therapies. Same-sex attractions and behaviours are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, potentially especially in youth and early adulthood. This should raise serious questions about the legitimacy of the MoU's portrayal of same-sex attraction and behaviour as the only option to be embraced by those minors or adults who might otherwise desire the option of exploring change.

D. The Reality of Sexual Fluidity Underscores the Impropriety of Prohibiting Change-exploring Talk Therapies.

86. Although no reputable scholar can now deny that the components of sexual orientation evidence significant fluidity for many non-heterosexual persons, the adamant contention of SOCE ban supporters is that such naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-exploring talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-exploring talk therapies often address these exact influences with their clients. For example, same-sex attraction fluidity is known to sometimes occur in

response to changes in emotional and romantic attachments. Hu et al. (2016) reported, "The results suggested that people who report same-sex attractions with no relationship or an opposite sex partner were more likely to shift their same-sex attractions than those who reported a same-sex relationship" (p. 658). In evaluating neurobiological research, Diamond and Rosky (2016) noted that "...one possibility [for shifts in sexual attractions] is that the formation of emotional attachments may facilitate unexpected changes in sexual desire" (p. 370). Similarly, Manley et al. (2015) assert, "...research on sexual fluidity suggests that, for some people, relationships may, in fact, influence sexual orientation, meaning that emotionally intimate relationships may lead to sexual attractions toward a gender to which one had not previously been attracted" (p. 168). Change-exploring talk therapy may address exactly such influences, assisting clients with their relationships in ways that for some may facilitate genuine shifting in sexual attractions and behaviours.

87. Presently, there are principally political obstacles to acknowledging some people can be their own agents of change in a process assisted by change-exploring talk therapy, including both minors and adults. Therapists who engage in this work report such experiences with some regularity, though certainly not for all clients. Research in this arena is of course very desirable, but hard to come by, for many reasons. Demands for such research seem to ignore the fact that (1) it is quite difficult to study a therapy process that is being made illegal, (2) funding sources for such research typically have vested interests in the outcomes as do the researchers, (3) obtaining findings favourable in any way to change-exploring talk therapies will likely result in the marginalisation and professional ostracisation of the researcher (Wood, 2013). It appears there will need to be a change, or at least a significant shift, in the ideologically unbalanced professional culture of psychology before we can undo the current politically required foreclosure on the science of talk therapy-assisted fluidity in same-sex attractions and behaviours. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148).

E. Professional SOCE Bans Target Speech, Not Aversive Practices.

88. There is now clear evidence from state legislative proceedings in the U.S. that the intent of bans is to stifle therapist speech and not certain aversive practices. Across the U.S. where ban legislation for minors has been debated, politicians are hearing testimonials that directly or by implication associate SOCE provided by licensed therapists with painful aversive techniques such as shocking genitals, chemically induced vomiting, taking ice baths, and the like. This caricature of contemporary change-exploring talk therapies as promoting such

child abuse is disingenuous, as was revealed in the legislative process surrounding proposed therapy bans in the states of Washington in 2015 and Utah in 2019. In both instances, amendments were made in committee that would have preserved a legal prohibition on the harmful aversive techniques but would have specially protected therapist speech. In the Utah example, the amendment would even have penalised guarantees of "a complete and permanent reversal in the patient or client's sexual orientation."

89. Nevertheless, despite the prospect of bipartisan support for these bills, proponents pulled the legislation, complaining they did not go far enough despite their targeting of the same aversive practices that were prominently mentioned as a basis for these bans (Backholm, 2015; "Watered down anti-conversion therapy bill," 2019). Particularly telling were the comments by University of Utah College of Law professor Clifford Rosky, who developed the original ban bill in Utah, as reported in the local gay press: "Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades," Rosky continued. What they do these days, he said is talk therapy. "As we know, words are just as damaging to children."

90. Clearly then, proponents of change-exploring talk therapy bans are aware that allowing abusive aversive practices to be associated with contemporary professional SOCE is fundamentally dishonest. Accordingly, it is for ban proponents to identify the kind of words change-exploring talk therapy practitioners might say to minors that are capable of damage analogous to the discredited practices outlined in paragraph 79 above.

91. A recent high-profile example of the dangers of politicians, policymakers, and media relying on personal SOCE anecdotes to justify change-exploring talk therapy bans involves Sam Brinton. Brinton is well-known for his high-profile activism against "conversion therapy." He has been the face of LGBT+ activism in this arena for over a decade, known for his gripping narrative of being the victim of torturous aversive conversion practices as a child.

Since Brinton came to prominence in 2010, the list of organisations and causes with which he has been prominently associated reads like a who's who of LGBTQ+ and progressive activism (Brinton, 2022). These include the following:

1. Head of advocacy and government affairs for The Trevor Project from 2017-2019.
2. Founded The Trevor Project's *#50Bills50States* campaign, which focuses on ending the practice of "conversion therapy" within the United States and eventually, worldwide.

3. Advisory committee co-chair of the National Center for Lesbian Rights #*BornPerfect* campaign through at least 2015.
4. Principal officer for the Washington DC chapter of the Sisters of Perpetual Indulgence (an LGBTQ charity and human rights group).
5. Testifying about his "conversion therapy" experience before the United Nations Convention against Torture in 2014.
6. Testifying before state and city legislators in Massachusetts and Florida in favour of legislative bans on "conversion therapy."
7. Testifying by video to the Iowa Board of Medicine in 2016 in favour of administratively banning "conversion therapy."
8. Featured in such publications as the New York Times, The Washington Post, Playboy, and Time.
9. Co-author with Douglas Haldeman of a chapter in the 2022 book, *The Case Against Conversion Therapy*, edited by Haldeman and published by the American Psychological Association, where he shares his story once again on page 196 (Grey et al., 2022).
10. Told his story to President Obama, whom he says was moved to tears and two weeks later made a formal statement standing against conversion therapy.
11. Appointed under the Biden administration to be the deputy assistant of spent fuel and waste disposition at the Office of Nuclear Energy in February of 2022.

    Brinton was relieved of those duties in November of 2022 subsequent to being charged with felony theft for stealing luggage from numerous airports across the United States. He was fired from the Department of Energy in December, 2022.

92. As a result of Brinton's loss of credibility, renewed interest in his harrowing account of "conversion therapy" torture occurred, leading to his abuse narrative coming apart in an excruciatingly humiliating manner. Family members have publicly declared his entire story a fabrication that never occurred (Hernandez, 2023). Yet the bigger issue is how is it possible such an unreliable and fantastical account of "conversion therapy" was not questioned long before now? And why did it take an apparent dramatic and public crime by Brinton before questions about his entire narrative began to be seriously examined? At the very least, politicians hearing personal accounts of abuse allegedly perpetrated by change-exploring therapists need to demand clear and unambiguous details, such as names, dates, locations, and the like. Otherwise, such "evidence" should be thrown out.

F. The Limited Understanding of the Dynamics of Stigma and Discrimination.

93. Proponents of change-exploring talk therapy bans typically frame a significant degree of their arguments concerning harm on the negative consequences of stigma and discrimination. While these factors certainly can have deleterious consequences for those with non-heterosexual sexual orientations, this possibility must be placed within a broader context and balanced by additional considerations.

94. From an overall perspective, the meta-analytic research (which summarises results over multiple studies) on the association between perceived discrimination and health outcomes indicates that the strength of this relationship is significant but small (Pascoe & Richman, 2009). Schmitt, Branscombe, Postmes, and Garcia's (2014) updated meta-analysis found that LGB-related discrimination (i.e., heterosexism) explained less than 9% of the relationship between discrimination and well-being and discrimination and psychological distress. Furthermore, research into what influences this association has often found either no significant role or counterintuitive relationships for theoretically linked factors such as various coping strategies, social support, concealing one's LGB identity, and identification with one's group (i.e., claiming a gay identity) (Denton, Rostosky, & Danner, 2014; Rogers, Hom, Janakiraman, & Joiner, 2020; Schmitt et al., 2014). For example, data suggest that the impact of "internalised homophobia" for understanding risk behaviour among men who have sex with men (MSM) is now negligible and, "The current utility of this construct for understanding sexual risk-taking of MSM is called into question" (Newcomb & Mustanski, 2011, p. 189). By contrast, polydrug use by these men continued to be a strong predictor of risky sexual behaviour. Similarly, a meta-analysis of studies examining the higher substance use rates among LGB youth compared to their heterosexual peers concluded that internalised homophobia was not a significant predictor (Goldbach, Tanner-Smith, Bagwell, and Dunlap, 2014). Such findings should be sufficient to indicate that there is a great deal left to be understood about this entire field of study.

95. Other lines of inquiry suggest that sexual orientation stigma and discrimination alone are far from a complete explanation for greater psychiatric and health risks among non-heterosexual orientations. Goldbach et al. (2014) discovered that the factors having the greatest relationship to substance use in LGB youth were not distinct from those reported by teens in the general population, regardless of sexual minority status. Victimisation that was not specifically gay-related had the strongest association with substance use for these youth. Mays and Cochran (2001) reported that discrimination experiences attenuated but did not eliminate associations between psychiatric morbidity and sexual orientation. The associations between non-heterosexual orientation and poorer mental health have persisted over time with recent studies showing the same effects as older studies despite a more accepting culture (Branstrom &

Pachankis, 2018; Sandfort, de Graaf, ten Have, Ransome, & Schnabel, 2014; Semlyen, King, Varney, & Hagger-Johnson, 2016).

96. The issue of suicide among non-heterosexual persons is worthy of great concern. Yet contrary to a singular reliance on minority stress theory to explain sexual orientation disparities, research is discovering that suicide-related ideation and behaviour disparities are not uniformly decreasing with the greater social acceptance of LGB people, both among minors and adults (Meyer et al., 2021; Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Wang, Ploderl, Hausermann, & Weiss, 2015). Men with same-sex attractions and behaviours were found to have a higher risk for suicidal ideation and acute mental and physical health symptoms than heterosexual men in Holland, despite that country's highly tolerant attitude towards homosexuality (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006; de Graaf, Sandfort, & ten Have, 2006). Even in highly tolerant countries such as Sweden and Denmark, same-sex married individuals evidenced a higher risk for suicide than other married persons (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016; Erlangsen et al., 2020). Wang et al. chastised researchers studying suicidality among non-heterosexual persons for their failure to consider other common factors in the general suicide literature: "It is notable, however, that certain areas of mainstream suicide research—e.g., consideration of biologic factors, psychological factors (e.g., personality traits), and stressful life events—have not been addressed in suicide research among sexual minorities to date" (p. 499). They reported neither mental disorder nor discrimination has been shown to explain the excess risk of suicide attempts among non-heterosexual people. A study by Skerrett, Kolves, and De Leo (2014) discovered that while LGB people who died by suicide had a higher incidence (65.7%) of interpersonal problems prior to death than their heterosexual counterparts (33.3%), they actually had *lower* levels of family conflict (5.7% to 17.1%).

97. Resent research examining three cohorts of sexual minorities (born between 1956-1963, 1974-1981, and 1990-1997) predicted improvements in the social and legal environments would result in reduced psychological distress and suicidality over time that would be reflected sequentially in these cohorts (Meyer et al., 2021). However, they found exactly the opposite results: "…members of the younger cohort reported higher levels of distress than both the middle and older cohorts, and the middle cohort reported a higher level of distress than the older cohort" (p. 12). With regard to lifetime suicide attempts, they discovered, "…30% of the younger cohort, 24% of the middle cohort, and 21% of the older cohort reported at least one suicide attempt" (p. 12). Similarly, a recent study of sexual minority youth reported "…despite societal improvements in visibility, acceptance, and legal protections for sexual minorities, disparities between sexual minority groups and heterosexual groups

remain significant, and for some groups SI [suicidal ideation] increased" (Stuart-Maver et al., 2023)

98. Studies outside of Western culture appear to indicate that culture may play a significant role in this literature as well. Using an LGB sample from China, Shao, Ching, and Chen (2018) found that minority stress was not related to psychological maladjustment, whereas respect for parents and perceived parental support were associated with positive adjustment. The authors conclude that the minority stress model cannot be generalised to individuals living in cultural contexts that emphasise family connections over one's sexual identity. This may have relevance for non-heterosexual persons who identify with conservative religious communities, many of which adhere to less individualistic cultural values (Rosik, Lefevor, McGraw et al., 2022).

Research in this area is almost entirely reliant upon self-reports of *perceived* discrimination, and the relation of this to objective discrimination is not well understood (Bailey, 2020). Self-report data make it difficult to tell how much of the association between perceived discrimination and well-being or psychological distress reflects the effects of perceptions of discrimination per se and how much is the effect of actual encounters with discrimination and negative treatment (Schmitt et al., 2014). Burgess, Lee, and van Ryn (2007) found that although perceived discrimination was associated with almost all indicators of poor mental health, adjusting for discrimination did not significantly reduce mental health disparities between heterosexual and LGBT persons, indicating that discrimination did not account for the disparity. Also supporting the notion that perceptions of discrimination may play a more prominent role than actual discrimination is research indicating minority stress theory can explain distress even among numerically and socially dominant groups, such as Christians (Parent, Brewster, Cook, & Harmon, 2018).

i. Alternatives to Minority Stress Theory.

99. The relationship of sexual orientation related stigma and discrimination to psychological and physical well-being among LGB persons is undoubtedly complex, and no single theory is likely to provide a universal explanation. Lick, Durso, and Johnson (2013) observed that the mechanisms linking sexual orientation-related stigma to physical health outcomes remain poorly articulated and causality cannot be inferred. In spite of these uncertainties, minority stress theory (Meyer, 2003) has assumed a favoured status in academic and policy discussions, including discussion related to prohibiting professional change-exploring therapy. This theory posits that experiencing or even fearing stigma specifically related to one's LGB identity arouses feelings of distress that can have profound consequences for the well-being of LGB persons. Opponents of change-exploring talk therapies often view them as

inherently stigmatising and discriminatory (and thus responsible for subsequent emotional and physical distress), but this is a dubious assertion given the substantial uncertainties surrounding minority stress theory.

100. Indeed, as Savin-Williams (2006) has observed, evidence for the causal pathway of this theory (i.e., sexual orientation to discrimination to mental and physical health disparities) is "more circumstantial than conclusive" (p. 42). McGarrity (2014) reported that LGB individuals are more highly educated than the general population, a finding not consistent with an unqualified minority stress position. She also indicated that the lower income levels of gay and bisexual men may not stem from discrimination but from their tendency to pursue "typically female" fields of study in college. Another study found that components of minority stress predicted no more than 5% of non-heterosexual drug and alcohol usage (Livingston, Oost, Heck, & Cochran, 2014). Even if it were to be (and it clearly has not been) proven that change-exploring talk therapies with minors were a form of stigma, Wald (2006) asserted that, "While the presence of stigma is clear, the research does not find that it has a significant harmful impact on the children's mental health" (p. 399). Important alternative theories have been proposed to challenge or supplement the causal assumptions of the minority stress view.

101. **Mediation theories**. Some theories with empirical support suggest that other factors indirectly mediate the pathways linking discrimination and stigma with disparities in LGB psychological health (Hatzenbuehler, 2009). Other theories assert that LGB discrimination and stigma may itself mediate the relationship between other factors that result in such disparities. In other words, specific sexual orientation discrimination or stigma may be minimally related or unrelated to psychological distress and physical health in the absence of certain intra- or interpersonal processes (Schumm, 2014). While many theoretically favoured factors thought to influence LGB health disparities have been questioned (as noted above), several examples of other mediating factors can be provided.

102. Recent literature also finds that particular emotion/avoidant-based coping mechanisms used by people reporting same-sex attractions can almost entirely account for the effects of this perceived discrimination (Whitehead, 2010). For example, the inability to regulate one's negative emotions was found to be a primary contributor to the pathway from sexual minority stressors and physical health symptom severity (Denton et al., 2014). In addition, differential rates of health problems resulted from sexual orientation-related differences in coping styles among men, with an emotion-oriented coping style mediating the differences in mental and physical health between heterosexual and homosexual men (Sandfort, Bakker, Schellevis, & Vanwersenbreeck, 2009). Passive coping style has been found to mediate mental health disparities

between LGB and heterosexual youth (Bos, van Beusekom, & Sandfort, 2014) while emotion-focused coping (the ability to regulate negative emotions) mediated physical health disparities between adult LGB and heterosexual individuals (Denton et al., 2014). In another study, controlling for unmeasured familial confounding factors by comparing sexual minority adolescents to the same-sex, nonminority co-twins, almost entirely attenuated the effect of sexual minority status on psychological health (Donahue et al., 2017). Rumination (the tendency to passively and repetitively focus on one's distress and distress-related circumstances) has also been found to mediate the relationship between stigma and distress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009; Timmins, Rimes, & Rahman, 2020).

103. Worries among sexual-minority youth concerning friendships and never finding a romantic partner have also been observed to mediate such disparities (Diamond & Lucas, 2004). Health disparities between gay and heterosexual men may also be mediated by the emotional and physical stresses of living with HIV/AIDS or other related physical ailments (Lick et al., 2013). In one study, disparities in heart disease, liver disease, digestive problems and urinary incontinence disappeared after accounting for HIV status (Cochran & Mays, 2007).

104. **Stress sensitisation theory**. As noted earlier, there is substantial evidence that LGB-identified persons have a much greater prevalence of adverse childhood experiences (ACEs), including emotional, physical, and sexual abuse (Blosnich & Andersen, 2013). The Stress Sensitisation Model hypothesises childhood adversity and trauma sensitise individuals to subsequent stress and increase reactivity via both psychological and physiological mechanisms that decrease one's ability to regulate emotions (Hammen, Henry, & Daley, 2000), heightening perceptual tendencies that may moderate and amplify the experience of minority stress. Consistent with this theory, Austin, Herrick and Proescholdbell (2016) reported that once ACEs were controlled, sexual orientation disparities disappeared for physical health, current smoking, and binge drinking and were notably reduced for mental health, HIV risk behaviours, depression, and disability.

105. Bailey (2020), following Wang et al. (2015), has recently criticised the failure of minority stress researchers to consider alternative models. In line with a stress sensitisation perspective, he asserts that non-heterosexual persons increased prevalence of mental health problems could, at least in part, be the cause, rather than the effect, of increased self-reported experiences of stigmatisation, prejudice, and discrimination. He observed, "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" (p. 2267).

106. **Non-heterosexual lifestyle theory**. This perspective posits that LGB lifestyles are inherently riskier than those of heterosexuals because of certain features of LGB social communities (Vrangalova & Savin-Williams, 2014). Schumm (2014) has suggested that differences in conduct between non-heterosexuals and heterosexual persons rather than sexual orientation identity may lead to or reinforce discrimination. These behaviours may include antisocial behaviours, unsafe sexual practices, and drug use. For example, Hatzenbuehler, Keyes, & Hasin (2009) found that drug use as a psychiatric disorder increased over time for LGB persons in states that had *more* protective policies. Higher substance use may be due to many LGB communities being structured around bars and clubs (Trocki, Drabble, & Midanik, 2005, 2009).

107. **Common factors theory**. This theory asserts that the elevated health problems among non-heterosexuals could be directly or indirectly due to genetic or environmental "common causes" of both health risks and nonheterosexuality (Vrangalova & Savin-Williams, 2014; Zietsch, 2012). Gender non-conformity, and divergence in behaviour, personality, and identity from those typical of one's sex are likely influenced by the same genetic and neurodevelopmental factors as non-heterosexuality, and therefore may be linked to both victimisation and mental health regardless of sexual orientation. Other personality traits may be implicated as common causes as well. Increased internalising (e.g., self-harm) and externalising risk behaviours (e.g., sexual risk-taking) may be due to direct or indirect shared genetic effects between non-heterosexuality and neuroticism or sensation seeking, rather than non-heterosexuality *per se* (Bailey, 2020). Common causes could also be environmental. For example, to the extent the same environments (e.g., large cities, college campuses, night clubs) that provide opportunities for exposure to sexually arousing stimuli also provide opportunities for engagement in various risk behaviours or carry other health risks, this could be a common cause for both health risks and non-heterosexuality.

108. The review article by Vrangalova and Savin-Williams (2014) is particularly intriguing in that they focused on psychological and physical health disparities among mostly heterosexual individuals. The mostly heterosexual (MH) orientation is characterised by a strong presence of other-sex sexuality and a slight amount of same-sex sexuality. MH may comprise about 4% of men and 9% of women in the general population (Savin-Williams & Vrangalova, 2013). Because MH persons tend to view themselves and are viewed by others as essentially heterosexual in their sexual orientation and lifestyle, they are plausibly exposed to much less sexual orientation discrimination and stigma than LGB-identified persons. One study reviewed indicated that only 8% of MH

teenagers reported experiencing sexual orientation-based discrimination. Yet Vrangalova and Savin-Williams (2014) reported that MH individuals are closer to bisexuals than heterosexuals in their health risks (see also Rosario et al., 2016). These authors further noted that people with exclusive opposite-sex or same-sex attractions may have less elevated health risks than individuals who experience any proportion of sexual attraction to both sexes. They concluded that, "This raises the possibility that it is something about non-exclusivity in sexual attractions or lifestyles that is linked to negative health outcomes" (p. 437).

109. The existence of such variant theories to explain the relationship (or lack thereof) of stigma and discrimination to psychological and physical health disparities between LGB and heterosexual persons argues strongly for the exercise of restraint when making public policy that rests in part on such disparities. The pathways to elevated health risks among non-heterosexuals may certainly include discrimination and stigma, but the extent, causal direction, and mediation of such a relationship is currently far from understood. Moreover, there is no direct empirical basis for linking change-exploring professional care with such health disparities. It is therefore both simplistic and unscientific for proponents to imply a causal link between the practice of professional change-exploring talk therapies and health disparities among non-heterosexual youth or adults.

ii. Some Health Outcomes Are Likely Based in Anatomy More Than Stigma.

110. In addition, some health risks, such as sexually transmitted diseases (including HIV) among gay men, may be influenced by stigma but are ultimately grounded in biological reality. One comprehensive review found an overall 1.4% per-act probability of HIV transmission for anal sex and a 40.4% per-partner probability (Beyer, et al., 2012). The authors noted, "The 1.4% per-act probability is roughly 18 times greater than that which has been estimated for vaginal intercourse" (p. 5). Swartz (2014) found sexually transmitted infections other than HIV/AIDS in 35.6% of men who had sex with men compared to 6.6% of the matched population sample of heterosexual men. Centres for Disease Control statistics indicate the rate of new HIV diagnoses in the United States among men who have sex with men has been more than 44 times that of other men (CDC, 2011). Young gay and bisexual men aged 13-29 accounted for 27% of all new HIV infections in 2009 and were the only group for whom new HIV infections increased between 2006 and 2009 (Prejean et al., 2011). In 2020 men who have sex with men accounted for 72% of new HIV diagnoses (CDC, 2022). Oswalt and Wyatt (2013) surveyed college students and found that while 69.5% of heterosexual males had never engaged in anal sex only 10.8% of gay males had not engaged in this sexual behaviour. Sharing such information with prospective change-desiring clients is not inherently manipulative but rather,

when balanced with other considerations, constitutes an ethically obligated aspect of informed consent.

iii. SOCE Not a Proxy for Stigma or Discrimination.

111. The lessening of stigma associated with "coming out" need not imply an affirmation of a gay, lesbian, or bisexual identity or the enactment of same-sex behaviour. Licensed change-exploring practitioners often encourage the client's acceptance of his or her unwanted same-sex attractions and the disclosure of this reality with safe others as a means of shame-reduction and a potential aid in the pursuit of change or, in cases where change does not occur, behavioural management of sexual identity. This typically occurs when clients desire to live within the boundaries of their conservative religious values and beliefs. While it is often assumed that conservative religious environments are stigmatising and harmful for sexual minorities by definition, this is by no means a universal finding (Barringer, 2020; Barringer & Gay, 2017; Lefevor et al., 2022; Rosik, Lefevor, McGraw et al., 2022). One study of black lesbian, gay, and bisexual young adults, 86% of whom were open about their sexual identity, found that, "Participants who reported lower religious faith scores and lower internalised homonegativity scores reported the lowest resiliency, while those reporting higher religious faith scores and higher internalised homonegativity reported the highest resiliency scores" (Walker & Longmire-Avital, 2013, p. 1727).

112. Referral for change-exploring talk therapies therefore cannot be designated as a proxy for harm-inducing family rejection and stigma, as proponents typically seem to assume. Only a few studies have directly examined the link between family rejection and health risks among minors (Saewyc, 2011) and the derived findings can be contrary to expected theories, such as the discovery that same-sex attracted boys who participated in more shared activities with their parents were *more likely* to run away from home and use illegal drugs than those who participated in fewer shared activities (Pearson & Wilkinson, 2013). The Ryan et al. (2018) study is the first of its kind in this arena, but with serious limitations that make it little more than a non-generalisable pilot study (Rosik, 2020). Thus, the MoU would unnecessarily and without scientific warrant eliminate the potential role of conservative religious values, social networks, and therapists and counsellors for ameliorating the effects of stigma in the context of change-exploring talk therapy. This would prevent clients from one means of prioritising their religious values above their same-sex attractions when these factors are in conflict. The contention that a desire to modify same-sex attractions and behaviours can only be an expression of self-stigma reflects a serious disregard for and misunderstanding of conservative religious and moral values (Jones, et al., 2010; Rosik et al., 2021). The UKCP code of ethics on change-exploring therapy calls a desire for change based on religious faith

"externalised and internalised oppression" (p. 4). While religious beliefs on sexuality and gender or anything else may be external for some, as may be true for individuals who subscribe to any worldview, this is by no means the case for all. Generalising this narrow interpretation is a failure at multicultural understanding and sensitivity and is discriminatory and stigmatising towards this minority within a minority. The assumption that a desire for sexual attraction or gender incongruence change can only come from external pressure disregards that individuals of traditional religions about sexuality and gender are capable of personal agency on this issue and can have preferences because they internally embrace the beauty of their religion. It also disregards the not uncommon exploration of change in speech-based therapy by sexual minority persons who previously spent considerable time living as LGBT+-identified individuals in LGBT+ communities. The UKBC code of ethics on change-exploring therapy, in perpetrating this false contention concerning client motivation, engages in serious religious bias and discrimination and codifies it to be systemic in the UKBC, a practice which is itself unethical.

iv. Encouraging Same-Sex Behaviour May Result in Risk-Justifying Attitudes.

113. Finally, some research has raised the possibility that some widely accepted theories germane to the discussion of stigma, discrimination, and health outcomes may in fact be incorrect. A longitudinal study of gay and bisexual men by Heubner, Neilands, Rebchook, and Degeles (2011) found that,

> "... in contrast to the causal predictions made by most theories of health behaviour, attitudes and norms did not predict sexual risk behaviour over time. Rather, sexual risk behaviour at Time 1 was associated with changes in norms and attitudes at Time 2. These findings are more consistent with a small, but growing body of investigations that suggest instead that engaging in health behaviours can also influence attitudes and beliefs about those behaviours. (p. 114)"

114. Thus, safe-sex norms and attitudes did not lead to reduced unprotected anal intercourse; rather, participants 'engagement in such HIV-risk behaviour appeared to change how they thought and felt about the behaviour and enhanced their willingness to engage in it. Such findings raise serious concerns about the impact the MoU, in that censorship which only allows for the affirmation and ultimate enactment of same-sex attractions may in fact increase HIV risk and negative health outcomes for some minors and adults who might otherwise have sought change-exploring talk therapy. Engaging in homosexual behaviour in adolescence has been linked with an elevated prevalence of many serious risk behaviours and emotional problems (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Outlaw et al., 2011). In addition, experiencing rape or sexual assault before the age of 16 has

been strongly associated with belonging to any non-heterosexual group (Wells, McGee, & Beautrais, 2011).

115. While stigma and discrimination are real concerns, they are not universal explanations for greater psychiatric and health risks among sexual minorities, some of which are likely to be grounded in the biology of certain sexual practices. Moreover, the effects of stigma and discrimination can be addressed significantly within change-exploring talk therapies for many clients, though this is no doubt hard to comprehend for those not sharing the religious values of change-exploring consumers. There is no longitudinal research involving consumers of change-exploring talk therapies that link the known effects of stigma and discrimination to the practice of change exploration. Change allowing counselling is simply *ipso facto* presumed to constitute a form of stigma and discrimination. This is in keeping with the persistently unfavourable manner in which change-exploring talk therapies are portrayed by the mental health associations. Change-exploring talk therapy practitioners and consumers are associated with poor practices as a matter of course (Jones, et al, 2010; APA, 2009, 2012, 2021a, 2021b). This arguably is a form of stigma and discrimination toward practitioners of change exploration, who ironically, as noted earlier, have developed their own set of practice guidelines that, when followed, can be expected to reduce the risk of harm to consumers of change-exploring talk therapies (ATCSI, 2018; Appendix 1).

G. Sexual Minorities who Reject an LGBT Identity: Overlooked by Research but Targeted by Therapy Bans.

116. As early as 2002, Shidlo and Schroeder observed a fundamental truth about many consumers of SOCE, stating, "…we have found that conversion therapists and many clients of conversion therapy steadfastly reject the use of *lesbian* and *gay*" (p. 249, authors' emphases). As noted previously, an emerging literature now suggests this rejection of an LGBT identity may be a marker for a constellation of characteristics this sexual minority subgroup often report. These individuals appear to be more active in conservative religious settings, full members of their church, less sexually active, more likely to be single and celibate or in mixed-orientation relationships, less accepting of their same-sex attractions, experience greater opposite-sex attractions, and place more importance on a family and child centred life (Lefevor et al., 2020; Rosik et al., 2021a). They also report modest to moderate helpfulness of change-oriented psychotherapy goals compared to LGB-identified individuals, who report modest to moderate harmfulness (Rosik et al., 2021b). However, contrary to conventional wisdom, sexual minorities who rejected an LGB identity did not appear to report more adverse psychosocial health than those who had adopted an LGB identity (Lefevor et al., 2020). These subgroups also reported similar degrees of resolution of their religious and sexual issues.

Similarly, Rosik et al. (2023) examined methods of addressing sexual orientation distress that reflected religiously motivated intentions to live in congruence with traditional religious values by restricting and otherwise discouraging same-sex attractions and behaviour. They found that sexual minority participants who were not LGB+-identified and who were theologically conservative reported these methods as mildly to somewhat helpful, whereas participants who identified as LGB+ and had no theological perspective reported these same methods to be mildly to somewhat harmful.

117. Examining the recruitment methods and sample characteristics of the most recent SOCE studies purporting harm supports the hypothesis that researchers have overwhelmingly investigated LGBT-identified sexual minorities to the general exclusion of sexual minorities who do not identify as LGBT (Rosik, 2023). Samples are often exclusively or mostly dominated by LGB-identified participants (Blosnich et al., 2020; Bradshaw et al., 2015; Flentje et al., 2013; Government Equalities Office, 2018; Green et al., 2020; Meanley et al., 2020; Ozanne Foundation Advisory Board, 2018; Ryan et al., 2020; Salway et al., 2020). SOCE researchers tend to recruit participants through the venues and networks most easily accessible to them; hence, samples usually reflect this selection bias in their focus on LGBT-identified persons.

118. Clearly, there is a significant problem when studies utilise LGBT self-identity as the sexual minority inclusion criterion, because by doing so they exclude those sexual minorities rejecting an LGB identity by definition and render these individuals invisible. Most research alleging harms from SOCE have therefore investigated a very different subpopulation of sexual minorities (those LGBT identified) than those sexual minorities who reject an LGBT identity and appear to often have more traditionally religious life paths and different experiences of contemporary, speech-based forms of SOCE. These serious limitations in the literature argue against generalising from SOCE studies conducted with LGBT-identified participants who allege harm to the modern SOCE experiences of those largely religious sexual minorities who reject an LGBT identity. Therapy censorship such as that proposed by the MoU unjustly targets this latter group of sexual minorities without any serious understanding or consideration of their attitudes toward and experiences of contemporary, speech based SOCE.

H. Argument from Authority

119. Proponents of therapy censorship often rely heavily on appeals to the authority of mental health organisations. Uncritical assessment of such appeals may be justified in areas of social science that do not intersect with significant political, legal, and advocacy interests. However, to do so in the arena of change-exploring professional care would be a serious and naïve mistake. As Sullins (2023) recently observed, “Referencing organisational resolutions also corrupts

the scientific debate. If those organisations are truly scientific, their institutional resolutions should be downstream from the research process, and not be cited in an attempt to influence it" (p. 7). In assessing such appeals, it is also critical to consider the cultural and ideological climate of organised psychology. What is undeniable is that both academic and organised psychology (particularly associational leaders) are essentially politically and ideologically homogeneous, left- of-centre groups.

120. Consistently in American (and very likely in Europe as well) the social sciences generally and in organised psychology specifically, self-identified liberals/progressives and Democrats outnumber self-identified conservatives and Republicans by ratios of 8:1 to 11:1 (Duarte, Crawford, Stern, Haidt, Jussim, & Tetlock, 2015; Jussim, Crawford, Anglin, & Stevens, 2016; Martin, 2016). Al-Gharbi (2018) examined extensive survey data for Heterodox Academy and concluded, "In other words, the lack of ideology diversity seems to be vastly more pronounced in social research fields than underrepresentation in terms of gender, sexuality and race." In other words, conservative perspectives are much less present among contemporary psychology faculty than even racial (Hispanic and Black), gender, and sexual minority viewpoints.

121. Within mental health associations, and most severely among their leadership bodies, left-of-centre ideological homogeneity appears to be entrenched (Silander et al., 2020). Former APA President Cummings reflected on his decades within APA leadership and observed (Cummings & O'Donahue, 2008):

"The APA has more than 100,000 members, associates, and affiliates, yet less than 200 elitists control its governance. They rotate year after year through its offices, boards, Council of Representatives, and its plethora of committees, in a kind of organisational musical chairs that ensures the perpetuation of political ideology and essentially disenfranchises the thousands of psychologists who might disagree. (p. 216) "

122. The APA lost 10% of its members between 2008 and 2013 and subsequently represented less than 44% of psychologists in America (Robiner, Fossum, & Hong, 2015). The American Medical Association now represents less than 20% of physicians in the country. These downward trends have in part come about due to these associations taking left-of-centre positions on several social and policy issues, alienating conservative members and leading many of them to disaffiliate. It is evident from these kinds of statistics that, when it comes to socially contentious issues such as change-exploring therapies, the mental health and medical associations likely do not speak for many of those professionals who practice in their respective fields.

123. Exacerbating this ideological dominance is the general lack of connection by APA leaders with the membership at large. For example, in the 2023 vote for

APA President only 8,475 of the APA's 118,000 members cast ballots ("Presidential election results" n.d.), meaning a paltry 7.2% of the membership (no doubt dominated by the most politically energised factions), felt it even worth voting. If such a level of membership involvement is indicative of general participation, this means APA resolutions, reports, and policy statements are approved by officials representing under 8% of the membership. There are no minority reports solicited for such documents, and no polling of the entire membership concerning such pronouncements is conducted.

124. The same lack of ideological diversity characterises the National Association of Social Workers (U.S.). The NASW leadership endorsed a total of 754 candidates in U.S. federal elections between 2014 and 2022—all but one of whom were affiliated with the broadly left-of-centre Democrat Party (NASW, 2018). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011).

125. These sorts of structural problems are not limited to mental health professional associations. Recently the American Academy of Paediatrics (AAP) released a policy statement, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, 2018). While a vast majority of clinics and professional associations worldwide encourage the "watchful waiting" approach to helping gender dysphoric children, the AAP statement repudiated that consensus and encouraged only gender affirmation. James Cantor, a gay psychologist, and well-known sexologist, was struck by this disconnect, carefully examined all of the statement's references, and was led to conclude, "...AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did the AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence" (author's emphasis) (Cantor, 2020, p. 312).

126. Examination of the AAP statement-making process indicated that a maximum of 36 members of the association (24 paediatricians and 12 members of the board of directors) directly approved the policy, which translates to a startlingly minute .05% of the AAP's 67,000 members (Kearns, 2018). Similar to the APA, the AAP statement was not presented to all members for a vote, and a minority report was not solicited. These considerations raise questions about the AAP's treatment of other subjects where there is inherent ideological and advocacy investment, including "conversion therapy."

127. These concerns are not even limited to the North American context. The Academy of Science of South Africa (ASSA) published a report, *Diversity of Sexuality*, in order to influence policy in Africa (ASSA, 2015). However, Diamond and Rosky found the report's claim of immutability of sexual orientation to be

in error: “The authors deployed the same exaggerations of scientific evidence that have long characterised immutability debates, concluding that ‘all sexual orientations are biologically based, largely innate and mostly unchangeable ’(p. 22).” (p. 10)

128. It is evident that the MoU also is a product of a serious and systemic lack of ideological diversity, with predicable negative consequences for generating an accurate and balanced portrayal of change-exploring therapies (McBrayer, 2024).

IV. Concluding Statements on Science

129. As this declaration has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA task force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the task force noted, the prevalence of success and harm from SOCE cannot be determined at present, and recent SOCE research does not advance the field sufficiently to provide a scientific basis for therapy censorship. Anecdotal accounts of harm, which generally have been a focal point of attention by supporters of bans, cannot serve as a basis for the blanket prohibition of a particular client goal of psychological care, however meaningful they may be on a personal level. It is negligent if not fraudulent that APA and other professional organisations accept such unverified claims that experiences of SOCE were “harmful” while dismissing much better documented claims that experiences of SOCE were “beneficial,” and were not “harmful” (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from change-exploring talk therapies (see http://voicesofchange.net ; https://changedmovement.com/ ; https://xoutloud.com/the-uk-heroes). Furthermore, as observed earlier, accounts of harm cannot tell us if the prevalence of reported harm from change-exploring therapies is any greater than that from psychotherapy in general.

130. The normative occurrence of spontaneous change in sexual orientation among youth and adults and the nontrivial degree of choice reported by some in the development of sexual orientation further bring into question the appropriateness of the MoU. Sexual orientation is not a stable and enduring trait among youth or adults, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviours with some minors and adults. Granted, high quality research is needed to confirm clinical reports of change. However, it should be

mentioned in this regard that the MoU would make further research on change-exploring talk therapies impossible, despite the APA task force's clear mandate that such research be conducted (APA, 2009).

131. Any purported concerns of harm anecdotally attributed to SOCE practice with minors or adults can most appropriately be remedied by the application of ethical principles of practice, including informed consent, and addressed through the existing oversight functions of ethics committees. The MoU is an ideological overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting there are age, gender, and non-heterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual individuals, some of whom are in opposite sex marriages where they have children, are well served by the MoU, a distinction it does not make.

132. Proponents of therapy censorship reason that because homosexuality is no longer considered to be a disorder, providing change-exploring talk therapies to minors or adults with unwanted same-sex attractions and behaviours is at best unnecessary and at worst unethical. This is an argument made in the UKCP Guidance on change allowing therapies[3] and the UKCP Conversion Therapy Consensus Statement (2014). However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned foci of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. While the MoU acknowledges some clients may experience significant stress over their conflict between religious beliefs and sexual feelings or behaviours, it decides for them, not only that they may not have help to diminish or change the unwanted feelings, but they may not even have help not to act on them, even if they are young, bisexual, mostly heterosexual, or in an opposite-sex marriage with family and feel they have some or a fair amount of choice. In this context, the selective attention the MoU gives to SOCE again hints at political advocacy rather than science as a primary inspiration. The resulting refusal to allow an individual help, even help to not act on feelings they do not want to act on, is not scientifically justified,

[3]UK Council for Psychotherapy (no date). UKCP's ethical principles and codes of professional conduct: Guidance on the practice of psychological therapies that pathologise and/or seek to eliminate or reduce same sex attraction. https://www.psychotherapy.org.uk/wp-content/uploads/2017/11/Reparative_Therapy_Paper_28022011.pdf (Retrieved 2020-7-14) Section 2: 1.3 "offering a treatment for which there is no illness."

substantially deprives clients of the right to direct their own sexual behaviour, and is tantamount to unethical practice.

133. Clients will not be well served if change-exploring talk therapy with minors or adults is judged *never* to be an appropriate modality for psychological care. Neither professional organisations nor activist associations should be substituting their judgment for that of a 17-year-old who is calculating a cost-benefit analysis in deciding whether to undergo change-exploring talk therapy, understanding through informed consent that fluidity in unwanted same-sex attractions may or may not occur. The APA is quite clear that it supports the competence of a 17-year-old girl to give consent to an abortion and a similar competence should be afforded to a 17-year-old considering change-exploring talk therapy. Therapists should not dictate the goals that clients can or cannot pursue as regards their sexuality, and neither should professional mental health associations or politicians.

134. Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents and adults (APA, 2008b) and the MoU implicitly protects this option. Is it reasonable that individuals who experience themselves to be the wrong biological sex be allowed to surgically remove healthy breasts and alter genitalia while others with unwanted same-sex attractions and behaviour are prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of high-quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne, et al., 2011). Furthermore, a recent highly touted study purporting to show reduced mental health treatment among transgender patients following surgery had to be retracted following critical scrutiny of its methods by several scholars (Branstrom & Pachankis, 2020). The authors were asked to reanalyse their data, and the results demonstrated “no advantage to surgery” (“Correction,” 2020). This inconsistency in the MoU between promoting irreversible and life-altering surgeries of questionable benefit while prohibiting change-exploring speech and goals in professional therapy raises concerns that the ethical reasoning of the MoU is perhaps ideologically biased and therefore is not ethical.

135. The task force Report (APA, 2009), and the mental health associations including the original MoU signatories that subsequently relied on it for their resolutions on SOCE, provide one viewpoint into research and reasoning which must be considered incomplete and therefore not definitive enough to justify a complete ban on change-exploring talk therapies with minors or adults. Currently, there is a lack of sociopolitical diversity within mental health associations (Duarte et al., 2015; McBrayer, 2024; Redding, 2001; Silander et al., 2020), which has an inhibitory influence on the production of scholarship in

controversial areas such as talk therapies that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base professional organisation position statements, ethical standards, or public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> "In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons...This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board)" (p. 90).

136. Such diversity is precisely what is lacking currently in professional mental health organisations and their associated scientific communities as regards the study of contested social issues related to sexual orientation, including SOCE (Duarte et al., 2015; Wright & Cummings, 2005). A similar criticism may be levelled at the signatories of the MoU on the basis of ideological bias.

137. Proponents of therapy censorship typically rely on false portrayals of professional change-exploring talk therapies as provided by mental health experts, greatly overstate what can be concluded from more recent sexual orientation change effort studies, unjustifiably link contemporary change-exploring talk therapies with the literature on stigma and discrimination, rely heavily on appeals to ideologically homogeneous and advocacy-invested sources of authority, and display in their one-dimensional presentation of the literature the likely presence of confirmation bias.

138. To sum up, a truly scientific response to the concerns of the signatories of the MoU would be to encourage bipartisan research into SOCE that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. Change-exploring talk therapy practitioners take seriously their responsibility to do no harm and would assuredly embrace such an opportunity (Jones, et al., 2010). Were proponents of the MoU not playing a winner-take-all approach to the issue of professional SOCE, there would undoubtedly be substantial ground both sides could agree upon that would address concerns regarding alleged harms and reported benefits from change-exploring talk therapies. Unfortunately, the approach taken by the MoU signatories represented only one (ideological) perspective on how to best address the challenges that come with the psychological care of individuals who experience unwanted same-sex attractions and behaviours. It is therefore a scientifically premature, and therefore an unjust and unethical violation of the

rights of current and potential change-exploring talk therapy consumers, their parents, and their therapists and should not be allowed to stand.

V. Practical Difficulties With the MoU

139. The most important paragraph of the MoU is paragraph 2, which states:

"For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis.

These efforts are sometimes referred to by terms including, but not limited to, 'reparative therapy', 'gay cure therapy', or 'sexual orientation and gender identity change efforts', and sometimes may be covertly practised under the guise of mainstream practice without being named.

1. *For the purpose of this document, sexual orientation refers to the sexual or romantic attraction someone feels to people of the same sex, opposite sex, more than one sex, or to experience no attraction.*
2. *For the purposes of this document, gender identity is interpreted broadly to include all varieties of binary (male or female), non-binary and gender fluid identities."*

140. The MoU and *Guidance on psychological therapies that pathologise and/or seek to eliminate or reduce same-sex attraction* are at odds with the known science as expressed in the position of other professional bodies. For example, the American Psychological Association's *APA Handbook of Sexuality and Psychology* (2014) [4] clearly states the role of environmental factors and potentially of early abuse in the development of same-sex sexuality and the possibility of family pathology in the development of transgender identity. The Royal College acknowledges the role of *"post-natal factors"*, thus excluding a genetics-only explanation for SSA. Yet there is no acknowledgement of this and numerous other nuances in the Memorandum or Practice Guidelines.

141. Paragraph 2 is particularly vague and presents a number of difficulties. This is the first occasion when the moral and etiological beliefs and assumptions of therapists are being targeted for censure rather than their conduct. This appears to be a form of "thought control". It raises so many questions that need to be asked, for example:

[4] https://www.apa.org/pubs/books/4311512

a. First, in the ethically provided change-exploring talk therapies to which I am referring, the therapist does not set the goals of therapy, so the therapist's viewpoint or assumptions or preferences are not the issue, but rather the views and assumptions and preferences of the client. So one question that might be asked is, if the client reports having same-sex attraction (SSA) and same-sex behaviour (SSB), does not feel these represent the authentic self, and therefore wishes to explore SSA fluidity and reduce SSB, should the therapist just instruct the client "you cannot have this goal and I cannot help you?" In this sense, the MoU suggests that the goals of the client must be superseded by the goals of the therapist.
b. Secondly, there are no actual practical examples of what might constitute therapist speech that would be considered "conversion therapy" and therefore place the therapist in ethical/legal jeopardy. Without such examples, the MoU is simply a broad threat without clear guidance as to how a therapist should navigate these waters.
c. Thirdly, does "sexual orientation change efforts" encompass discussion of issues arising from a client's family circumstances, personal background, experiences, past physical or sexual abuse, or any of a number of other factors that may affect a client's feelings of attraction to the same sex (or related behaviours) even though sexual orientation or same-sex attractions and behaviours may not be specifically discussed (or even mentioned)? What level or subject of discussion constitutes an "effort"?
d. Fourthly, does the term encompass any discussion concerning a client's own self-determined or self-chosen objectives or desires? Again, these should be neither decided nor advocated by therapists nor their professional associations. These might include a desire to minimise or manage unwanted same-sex attractions and behaviours or related feelings. To whose "efforts" does the statute apply? Is a therapist engaged in an "effort" if the client has determined the therapeutic goal?
e. Fifthly, does the MoU apply to exploring the unwanted SSA and behaviour fluidity of "mostly heterosexual" individuals? Is "mostly heterosexual" a "sexual orientation" covered under the MoU?
f. Sixth, does therapy-assisted exploration of the *fluidity* of unwanted SSA and behaviours constitute "sexual orientation change efforts"?

142. Consider a Catholic priest who is bi-sexual and wishes to pursue chastity in his counselling. If, sometime after this counselling, he adopted primarily gay identity and decided to sue his former therapist, does the MoU give him grounds to do so? Would the assistance of the therapist in such a client's pursuit of chastity constitute "efforts to change behaviours" that would constitute "sexual orientation change efforts" or efforts to "suppress" expression of same-sex attraction under the definition?

143. A significant number of gender-incongruent individuals also experience regret at some point after transitioning. Such potentially disgruntled transgender clients could sue their therapists by claiming their therapeutic process led to an unwanted change in gender identity. Cases such as this are already occurring and are likely to increase in the future (Holt, 2020).

144. Paragraph 3 states: '*Signatory organisations agree that the practice of conversion therapy, whether in relation to sexual orientation or gender identity, is unethical and potentially harmful.*'

145. The issue of harm raises the question of whether one takes into account the data on deterioration from psychotherapy in general. There are no longitudinal studies on "conversion therapy" to discern what distress the client brings into therapy versus derived from therapy.

146. So, you could ask: Are there any studies of "conversion therapy" that are longitudinal, and which assessed for suicidality and psychology distress prior to beginning such therapy? If not, how do you determine if the emotional distress and suicidal thoughts reported by participants resulted from the therapy itself or existed prior to beginning therapy?

147. Paragraph 5 gives permission for clients to explore their sexual orientation. Are they allowed to explore this only in one direction, i.e., toward an LGBT identity?

148. The last part of this paragraph, again commits the error of assuming the practitioner is the one determining the goals of therapy rather than allowing the client to choose their preferred goal. If a socially transitioned transgender minor decides they really prefer to be cisgender and want assistance, must the practitioner refuse to help?

149. Paragraph 11 fails to consider that the MoU itself discriminates against clients who wish to explore the fluidity of their same-sex attractions, for example, the heterosexually married man with some SSA who wishes to enhance his heterosexual identity by exploring the degree to which his SSA and/or same-sex behaviours can be diminished.

VI. Conclusions

150. The MoU suffers from viewpoint discrimination, given the fact that no dissenting view is permitted.

151. Valuing ideological diversity and scientific methodology is one of the cornerstones of modern science and therefore to make ideology subservient to scientific, factual and empirical data is scientifically dangerous. When the

Memorandum of Understanding was under discussion, professionals with other perspectives were barred from the discussion. What has emerged from the "progressive" agenda is a monoculture by which research, accreditation, and discipline-cultures subscribe to only one ideological viewpoint and are therefore unchallengeable.

152. There appears to be a refusal to examine the counter-evidence, which is a hallmark of "confirmation bias"; results are valued more highly and subjected to less critical scrutiny when they align with pre-existing own viewpoints and desired outcomes.

153. Since 2014, scientific enterprise consistently refers to sexual "fluidity," and sexual "orientation" essentialism is increasingly challenged.

154. The MoU has substituted ideological bias for sound ethical reasoning. The signatories do not have the incontrovertible scientific evidence that must be required (1) to prohibit a client's fundamental and sacred right to self-determination, in regard to choosing a therapy goal of change in sexual attraction or behaviour, nor (2) to place an ethical prohibition on therapists or counsellors who are open to such a client therapy goal.

EXPERT DECLARATION

I declare the following:

1. That I understand that my duty in providing written reports and giving evidence Is to help the court; and that this duty overrides any obligations to the party by whom I am engaged or, the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees Is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am Instructed If, between the date of my report and the hearing, there ls any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all the information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.

8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that night adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.

9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, Including my Instructing lawyers.

10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.

11. I understand that –

    a. My report will form evidence to be given under oath or affirmation;

    b. Questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

    c. The court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;

    d. The court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;

    e. I may be required to attend court to be cross-examined on my report by a cross-examiner assisted by an expert;

    f. I am likely to be the subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12. I have read Part 35 of the Civil Procedure Rules and Part 3.3 of the Criminal Procedure Rules, the accompanying practice direction, and the Guidance for the instruction of experts in civil claims and I have complied with their requirements.

13. I am aware of the practice direction on pre-action conduct. I have acted in accordance with the Code of Practice for Experts.

…….
Christopher Rosik

…….

January 2024

Appendix 1 – Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy
https://drive.google.com/file/d/1KLWcldYkCKNAK76NApYN8xA1x0aIfIXE/view?usp=drive_link

Appendix 2 – Curriculum Vitae
https://drive.google.com/file/d/1tAPNqBgy9hh9Y59RCx-a_uGck909wz9l/view?usp=drive_link

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