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

LAURA HAYNES, PH.D.,
CALIFORNIA LICENSED PSYCHOLOGIST

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

Instructed by:
Andrew Storch Solicitors Ltd
City Gate
95-107 Southampton St
Reading RG1 2QW

Prepared by:
Laura Haynes, Ph.D., California Licensed Psychologist

Correspondence Address:
Executive Board,
International Foundation for Therapeutic and Counselling Choice
Country Representative for the USA (IFTCC.org)
Chair, Science and Research Council
P.O. Box 653, Tustin, CA USA

Synopsis of Author's Background
After more than 40 years of providing psychological services, Dr. Haynes retired from clinical practice as of 1 June 2018. She is devoting more time to speaking and writing about same-sex attraction and gender incongruence change. Her writing has been read internationally.

Education:
- Ph.D.: Rosemead School of Psychology, La Mirada, CA (now a graduate school of Biola University)
- M.A.: Rosemead School of Psychology, La Mirada, CA (now a graduate school of Biola University)
- M.A.: Fuller Theological Seminary, Pasadena, CA
- M.A.: Southern Methodist University, Dallas, TX
- B.A.: Westmont College, Santa Barbara, CA

Experience:
- Over 40 Years Clinical Experience
- Licensed California Psychologist #PSY5850

Organisations:
- Executive Board Member, U.S.A. Country Representative, Chair of the Science and Research Council, International Foundation for Therapeutic and Counselling Choice, (iftcc.org)
- Research Committee, Alliance for Therapeutic Choice and Scientific Integrity (therapeuticchoice.com)
- Sex and Gender Identity Task Force, Christian Medical and Dental Associations
- Former President: Christian Association for Psychological Studies—Western Region
- Lifetime Member: American Psychological Association

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By Laura Haynes, Ph.D.

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PROBLEMS WITH THE MoU

I. INTRODUCTION

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

2. This report has been prepared following the instructions of Andrew Storch solicitors Ltd. who acts 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 clients.

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

5. It is likely that prohibiting psychotherapy for those who wish to explore options in relation to their sexual or gender feelings and behaviours will have seriously harmful implications.

6. There is also a summary report of this full report.

II. SERIOUSLY HARMFUL IMPACTS OF THE MoU ON CLIENTS AND THERAPISTS

7. **The MoU has appeared in 2 main versions. The first version appeared solely in 2015**. It stated, "The MoU is informed by a position that efforts to try to change or alter sexual orientation through psychological therapies are unethical and potentially harmful." Hence, this version applied only to sexual orientation. (MoU, Nov. 2015)

8. **The second version of the MoU was published in 2017 and has been lightly revised or updated a number of times.** (MoU, Oct. 2017; MoU, 2019; MoU, 2021; MoU, March 2022; MoU, Nov. 2022; MoU, April 2024; MoU, July 2024)

9. **The key passage of the current MoU, which is version 2, is in paragraphs numbered 1 through 3 which state (MoU, July 2024),**

> **1** The primary purpose of this Memorandum of Understanding (MoU) is the protection of the public through a commitment to ending the practice of 'conversion therapy' in the UK.
>
> **2** 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 practiced under the guise of mainstream practice without being named.

i) 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.

ii) 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.

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

10. **It may be noted that there is a Memorandum of Understanding on Conversion Therapy on the Island of Ireland that contains essentially the same content.**

11. **Some people experience distress from their same-sex sexuality or discordant gender identity. The methodologically best available research has found that therapy that is open to their desire to manage, decrease, or change these has, for many, strongly and clinically improved their psychological well-being, protected their health, protected their marriage and family they love, enabled them to begin a procreative marriage and a family or to be comfortably abstinent, and protected their observance of the religion of their heart. The MoU prohibits this therapy. This full report (book) and a summary report based on it present this research.**

    a. **Contemporary, ethical, change-allowing, mental health practitioners provide client-centred therapy that decreases distress and may or may not result in reduction or change in same-sex attraction or behaviour or discordant gender identity or expression. These therapists who are in professional organisations that are supportive of their work follow ethical guidelines.** (IFTCC Practise and Ethical Guidelines (PEG), 2023; Alliance Guidelines, 2017; Reintegrative Therapy Standards, 2017) They oppose therapist-imposed therapy goals, aversive and coercive methods, and guarantees of therapy outcomes wherever they may exist. (IFTCC Practise and Ethical Guidelines (PEG), 2023, preamble) They use evidenced-based trauma treatments and well-established, standard therapy methods therapists generally use around the world. Individualized plans for care are set collaboratively by therapist and client based on the best-available evidence, clinical expertise, and the client's characteristics, preferences, values, and beliefs.

b. **Therapists who are open to these client desires generally do not use the terms "conversion therapy" or "gay cure therapy" that are political utility terms.** The term "sexual orientation and gender identity change efforts" does "not differentiate between professional conducted psychotherapy and religious or other forms of counseling practice". (Rosik, 2016)

c. **While therapy that is open to these client desires is generally not a *form* of therapy, Reintegrative Therapy®** (Reintegrative Therapy, US Patent and Trademark Office, Reg. No. 5,771,624; ReintegrativeTherapy.com) **and Reparative Therapy®** (Reparative Therapy, US Patent and Trademark Office, Reg. No. 5,512,452; Nicolosi, 2009) **are specific therapy approaches** that are trademarked by the United States Patent and Trademark Office and that enjoy certain federal protections. Equating either of them in the U.S. with generic terms such as "conversion therapy", "gay cure therapy", or "sexual orientation change efforts" may swiftly lead to a lawsuit. Reintegrative Therapy® is a mixture of trauma and addiction treatments used for a wide variety of client concerns. Reintegrative therapists are, however, open to the desire of some clients to *explore* their sexuality.

d. **The characterisation of all change-allowing therapy as unethical or potentially harmful stigmatises and puts at risk client-centred, ethical, professional psychotherapy that has been found to be helpful and effective for many**.

12. The MoU forbids clients therapy to decrease distress about undesired or unfulfilling sexual or gender feelings or behaviour that may or may not result in changes in sexuality or gender identity when the desire for such therapy is based on a "viewpoint". It is belief based.

a. **Hence, the MoU is viewpoint or belief discrimination. It polices a therapist's or counsellor's *thoughts* as well as *speech* or consensual therapy conversations based thereon. In effect, it also polices a *client's* thoughts or viewpoint.** It forbids a *client* the right to choose a therapy goal based on a *client's* viewpoint that any sexual orientation or gender identity is inherently preferable to any other. The MoU polices the viewpoints, values, ethics, conscience, preferences, and beliefs of clients. In addition, it polices the right of clients to self-determination on matters as deeply personal as their own sexual and gender feelings and behaviours. **Hence the MoU polices a client's thoughts, speech, values, ethics, conscience, preferences, sexual feelings, sexual behaviours, gender identity, gender expression, many religions, and many cultures.**

b. **The MoU offers no scientific evidence as a basis that would justify such a far-reaching departure from the most fundamental of clients' rights, the right to self-determination. Incontrovertible scientific evidence should be required** to support depriving individuals of the right to self-determination, particularly in so many and such intimate and profound respects. In fact, however, the

MoU points to limited scientific evidence that supports its own viewpoint that change-allowing therapy is unethical or potentially harmful and ignores contrary evidence, as will be illustrated in this report.

13. **The UK Council for Psychotherapy (UKCP) accepts that "a client's *attraction* to a person or persons of the same or opposite sex may increase or decrease while they are receiving psychotherapy"** (UKCP, no date, guideline 3.3, bold added**). Hence the UKCP acknowledges the obvious reality that sexual attraction may change through life experience and in the course of psychotherapy. It is generally impossible to prove the therapy had no effect in such change.** In support of this UKCP statement, abundant robust research has established internationally that same-sex sexual attraction, romantic fantasies, behaviour, and orientation identity all commonly change through life experience. Gender identity also can change lifelong through life experience. It is generally accepted that psychotherapy leads to changes in life experiences. (More discussion of research regarding change is at "V. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan" and "VI. Discordant Gender Identity May Change Throughout the Lifespan".)

14. **It should in principle be possible for researchers, clinicians, and clients to discover and understand what life experiences are leading to these changes in sexuality and gender identity, and there is some research that indicates such factors. Clients should be able to inquire about and explore what is known. They should not have to fear that having conversations on this topic that may be of importance to them could result in repercussions to their therapist or in losing their therapist.** (More discussion of research identifying life experiences leading to changes at "V. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan".)

15. **While the UKCP acknowledges sexual *attraction* change may occur during the course of psychological interventions, if the MoU accepts such change, it does so only if there is no *goal* of change and no *viewpoint* that one sexual attraction is better than another. Lacking clarification, the question may be asked, may a psychological intervention be permitted under the MoU to bring about sexual attraction or gender identity change if there is no unapproved goal or viewpoint?**

    a. **Research supports the possibility of such an intervention. Sexual attraction changed in an unexpected way in a multi-methods, randomized controlled trial, considered gold standard research. In the U.S., researchers instructed women whose arousal was mostly heterosexual to practice a mindful attention psychological intervention.** Mostly heterosexual attraction is the largest sexual attraction category, second only to exclusively heterosexual attraction, and is larger than all other nonheterosexual sexual attraction categories combined (bisexual, mostly homosexual, and exclusively homosexual, in terms of the Kinsey scale). (Savin-Williams, Joyner, & Rieger, 2012, p. 106; Geary et al., 2018, p. 5; Diamond, 2014, in *APA Handbook*, chapter 20, vol. 1, pp. 634-635) The researchers expected the women's opposite-sex attraction to increase, which it did, and their same-sex attraction to increase, but it decreased. The women's subjectively reported feelings of

same- or opposite-sex sexual arousal or distraction mirrored their fMRI data. Neither researchers nor participants had a goal of change or held a viewpoint that one sexual attraction is better than another. (Dickenson & Diamond, 2018; Dickenson et al., 2020) Would the signatories of the MoU punish these researchers if they were in the U.K.? Would researchers be permitted to conduct follow-up research on this or another psychological intervention that effects sexual attraction change? Or does the MoU effectively suppress research into sexuality and gender identity change through psychological intervention?

b. **A form of change-allowing therapy that may come closest to meeting the MoU restrictions is Reintegrative Therapy®**. It is a specific therapy that enjoys federal trademark protection in the United States and that employs mindful self-compassion as one of its main methods, a psychological intervention in a category similar to the mindful attention intervention in the research just referenced above. The Reintegrative Therapy Association takes no viewpoint position about sexual orientation, as the MoU requires, but it does accept a client's goal of sexual attraction change (ReintegrativeTherapy.org) and was found to be moderately effective for such a therapy goal in an independent, prospective, longitudinal, quasi-experimental, naturalistic, repeated measures (at 6, 12, 18, and 24 months) study. Psychological well-being improved significantly, strongly, and clinically. This study did not have a comparison group (for example of people who had no therapy on a wait list or had an alternate activity) to clarify it was the therapy, and not life experience during the passage of time, that caused the significant changes reported for sexuality and psychological well-being, so more research is needed. (Pela & Sutton, 2021) A recent book edited by Haldeman, titled *The Case Against Conversion "Therapy"* (2022, published by the American Psychological Association with its disclaimer on the copyright page) distinguished change-allowing therapy that takes no viewpoint on sexuality from change-allowing therapy that does take a viewpoint on sexuality. It said, "This book does not address some of the more recent iterations of SOCE [sexual orientation change efforts] also known as 'conversion therapy lite.' These methods are promoted by individuals who profess not to have a bias against same-sex attraction and behavior but simply want to market treatments intended to diminish patients' unwanted same-sex desire and enhance their heterosexual response and function." (p. 8) Under the MoU, may individuals be allowed to have this therapy that has the purpose to decrease distress, potentially decrease unwanted same-sex attraction, and enhance opposite-sex response and does not base this therapy on a "viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other"? If the MoU allows individuals to have effective therapy if there is not an unapproved viewpoint, then anyone should also be permitted to have effective therapy without viewpoint discrimination.

c. **Some therapists concede that they believe sexual or gender trauma or other trauma may causally influence the development of same-sex attraction or**

behaviour or discordant gender identity or expression, and they treat such trauma believing the treatment may lead to sexuality or gender change. But they believe they are not conducting "conversion" therapy, because they affirm a viewpoint that same-sex sexuality and gender non-congruence are normal, even when they are symptoms of trauma, and because they do not accept a client's *goal* of change. If unwanted same-sex sexuality or unwanted gender discordance is the result of sexual or other trauma for some and treating such causes may lead to change, the client's goal of change is reasonable and warranted and should not be rejected. It is harmful to a client in such a case to reject the client's desire to explore their potential to fulfil this therapy goal or to insist to a client that experiences forced on them by trauma, that they feel do not represent their authentic self, must be treated as neutral or be affirmed.

d. If the MoU signatories allow psychological interventions that decrease distress and may bring about sexual *attraction* decrease or change when such decrease or change is *not a therapy goal* and is done with an MoU *approved viewpoint*, they should allow anyone psychological interventions that decrease distress and may bring about sexual attraction decrease or change when this decrease or change *is* a goal of therapy without viewpoint discrimination, for example to help clients save their marriages and families, to help them live more easily according to their religion that gives them happiness, or for whatever reason they wish.

16. Lack of clarity in the MoU on what may be treated under the restriction of viewpoint and therapy goal discrimination potentially leads to several unintended and seriously harmful consequences.

a. **Consider, for example, therapy to suppress or decrease casual same-sex behaviour in order to reduce risk of HIV transmission.**

i. **Standard therapies, LGB culturally adapted standard therapy, and LGB lay peer counselling have been shown in several sets of randomised, control trials, considered gold standard research, to significantly decrease casual same-sex partners and maintain change** at 6 months and 1 year follow up (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Reback & Shoptaw, 2014) or at 8 months from start of treatment. (Nyamathi et al., 2017) This research was conducted by LGB-identity-affirmative researchers to help men who have sex with men decrease drug use and risky sexual behaviour with the goal of reducing risk of HIV transmission. The research outcomes demonstrated that same-sex behaviour can be effectively decreased or suppressed through therapy.

ii. **In the language of the MoU, this research shows that "a therapeutic approach, or…model…which attempts to…suppress an individual's expression of sexual orientation…practised under…mainstream**

practice" can be effective, although the therapy was not based on the MoU censored viewpoint that any sexual orientation is better than another. Does the MoU permit effective therapy to help clients decrease same-sex partners, providing the therapist and client hold a viewpoint that no sexual orientation is preferable to any other?

iii. **There should not be a viewpoint test for receiving effective therapy.** If the MoU allows effective therapy to decrease same-sex behaviour under the condition that the therapist and client hold the MoU approved viewpoint, it should not deny access to effective therapy to decrease same-sex sexual behaviour for whatever reason the client chooses, without discrimination.

iv. **One of these studies found the therapy was *especially effective* for men who did *not* hold the MoU approved viewpoint.** These were men for whom same-sex behaviour was inconsistent with their values (values assessed as high "homonegativity). Three longitudinal studies and additional research have found that reduction of same-sex behaviour has also been successful for religious people who hold a viewpoint that one sexuality or gender expression is better than another. May individuals who do not hold the MoU approved viewpoint also have this effective help, or must they be denied based on their values or religious beliefs? (More research discussion on change through therapy at "X. The Best Available Research Supports That Change-allowing Psychotherapy Improves Mental Health and Is Effective" and "XV. Growing Evidence Shows Researchers Who Report Harm and Researchers Who Report Benefit Are Studying Different Sub-Groups".)

b. **Consider, for another example, a client who is an applicant to a Catholic seminary,** whose intention is to pursue becoming a priest, and who actually wants help to suppress expression of his same-sex sexual preference or even to suppress all sexual expression or to suppress gender-sex incongruent expression. If his therapy goal is not based on a viewpoint that any sexual preference or gender expression is any better than any other, may a therapist help him toward his goal? Or is it that if his therapy goal is based on his Catholic religious beliefs, he must be forbidden his desires? This would be religious discrimination. Or may he not be helped to suppress sexual or gender behaviour in any event? Prior to the existence of the MoU, clients had the right to decide their own goals for sexual or gender expression without interference and without discrimination based on viewpoints.

c. **Explicit clarity is important as to whether the MoU has taken into account the matter of helping clients suppress or change unwanted sexual behaviours, thoughts, or feelings that meet diagnostic criteria for a recognised psychiatric disorder when they are directed toward the same sex,** such as sexual obsessions or compulsions, and whether the client's viewpoint

is a determining factor in allowing effective treatment. The International Classification of Diseases, 11th Edition, recognises Compulsive Sexual Behaviour Disorder. (World Health Organization, 2022) It is notable that the lead author of the World Professional Association for Transgender Health Standards of Care, Version 7 (2012) and Version 8 (2022) specialises in treating compulsive sexual disorder, hence this LGBT-identity-affirmative therapist specialises in helping people suppress or reduce sexual behaviour that for some people is same-sex behaviour. (Coleman, Dickenson, et al., 2018) Is it the case that the MoU allows therapy to reduce sexual behaviour linked to a psychiatric disorder only if the behaviour is directed toward the opposite sex but not if it is directed toward the same sex? This case would be sexual preferences discrimination. If the MoU permits therapy to reduce sexual thoughts, feelings, and behaviours that are linked to a recognised psychiatric disorder and directed toward the same sex, it should permit help to make these reductions and to reduce associated attractions to engage in the behaviours for whatever reason the person desires without sexuality or viewpoint discrimination.

d. **It is not clear whether the MoU signatories have considered people who feel their LGBT feelings and behaviour were forced on them by trauma and do not represent their true self**. For example, the American Psychological Association's *APA Handbook of Sexuality and Psychology* (Mustanski et al., 2014, chapter 19, vol. 1, pp. 609-610) says childhood sexual abuse has "associative and potentially causal links" to having same-sex partners, based on research whose methods it praises. The Cass Report says, **"8.40** Early audits and research suggest that **ACEs [adverse childhood experiences] are a predisposing factor** [to gender dysphoria]. This was demonstrated from the earliest audit of the GIDS service (Di Ceglie et al., 2002) and in the systematic review. (Taylor et al, 2024, Characteristics of children and adolescents)" (Cass, April 2024, p. 119, bold added) Some clients may want to explore these adverse childhood experiences, heal, and be their authentic self. May they have this therapy goal? (Re gender dysphoria, see in this full report: "VII. Discordant Gender Identity May Have Treatable Psychological Causes".)

e. **Under the MoU, may people of diverse sexuality or gender identity have help to protect or save their marriage and family**? Many are already committed to an opposite-sex spouse they love and a family that they love and wish help to hold it together so they can go on being full time mums and dads. They want to stop ("suppress") same-sex sexual behaviour that is putting their marriage and family at risk. They also want help to decrease their same-sex attraction to engage in this behaviour they do not want and help to increase their opposite-sex attraction so they can enjoy their marriage more safely and easily. Preserving marriage and family is one of the most common reasons for a goal of sexual attraction or behaviour change in therapy. Some also aspire to explore their potential to form a procreative marriage in which they and their opposite-sex spouse may procreate and raise children together.

i. **Contrary to conventional wisdom, most same-sex attracted people by far are both-sex attracted.** (Diamond, 2014, in *APA Handbook, vol. 1*, p. 633; nationally representative studies: Savin-Williams, Joyner, & Reiner, 2012; Chandra, Mosher, & Copen, 2011; Laumann et al., 1994, Table 8.3B on p. 311; Mosher, & Copen, 2011, Table 11; Mosher, Chandra, & Jones, 2005, Table 17; Hayes et al., 2012, Table 2; Large cohort studies of New Zealanders: Dickson, Paul, & Herbison, 2003; Dickson, Roode, Cameron, & Paul, 2013. More research: Vrangalova & Savin-Williams, 2012) (More research discussion on this point at "IV. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan)

ii. **Most both-sex attracted people who are in a relationship are with the opposite sex.** (Heslin & Alfier, 2022, Tables 3 and 4; ONS, 2012 to 2020, Table 5b; Sullins, March 2024c, under point 3**;** Hu & Denier, 2023b; 2023a, Table A4; Herek et al., 2010, Table 8; Kaestle, 2019, figure 3 and p. 819; Jones, 2022, pp. 5-6.) (More research discussion on this point at "IV. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan)

iii. **Both-sex attracted people in an opposite-sex relationship may experience satisfaction that is real—80% in one study** (Lefevor, Beckstead, et al., 2019) (Yarhouse, Pawlowski, & Tan, 2003; Lefevor, Beckstead, et al., 2019; Pomeroy, 1972, pp. 76-77) (More research discussion at "IV. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan)

iv. **In studies of therapy with men who have this goal of change, about a third to a little more than half were married with children.** (41%: Sullins & Rosik, 2024; 42%: Karten & Wade, 2010, p. 87; 32%: Byrd, Nicolosi, & Potts, 2008, pp. 7, 16-17, 20; 55%: Throckmorton & Welton, 2005, p. 11) (More research discussion on this point at "IV. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan)

v. **Fathers were particularly successful at reducing same-sex partners** in a randomised controlled trial, considered gold standard research, for men who have sex with men (Nyamathi et al., 2017). **Also, men who were married to women, most of whom were fathers, were particularly successful** at reducing same-sex behaviour and attraction and also at increasing opposite-sex behaviour. (Sullins & Rosik, 2024, pp. 8-9, 13) (More research discussion at "X. The Best Available Research Supports the Safety and Effectiveness of Change-allowing Psychotherapy")

vi. **Some gender dysphoric people also may want help to align their gender identity with their sex when discordant gender identity or**

expression is putting their marriage and family at risk. They want to **"**provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority", according to Kenneth Zucker, world-renowned gender dysphoria specialist, and colleagues. (Zucker, Lawrence, & Kreukels, 2016, p. 237) Zucker advocated for this therapy to be accepted as ethical.

vii. **Lacking clarity, we consider whether the MoU may allow a therapist to help a client suppress or change same-sex sexual or discordant gender identity *behaviours* but not sexual attraction *feelings* or gender identity *feelings* which often underpin such behaviours. Therapy that helps to decrease unwanted behaviours often is achieved by helping to decrease the desire or attraction to engage in such behaviours.** The effectiveness of therapy that targets only behaviour and not underlying feelings of desire to engage in the behaviour may be limited in comparison to therapy that also helps decrease the desire to engage in the behaviour. It would be next to impossible, counter-productive, and absurd for a therapist to try to help a client reduce or change behaviours and at the same time take precautions to be sure the client's feelings of attraction to engage in those unwanted behaviours does not change. In addition, it is next to impossible for a therapist to completely separate therapy that could lead to change in a person's behaviour from therapy that could lead to change in the related feelings of attraction to engage in the behaviour, because attractions or feelings and behaviours are inextricably linked.

viii. **A testimony may help to illustrate aspiration to be in an opposite-sex marriage and a desire for therapy toward this life goal.** (IFTCC, 2024)

> **"I always had such a desire to one day see my wife walking down the aisle in a beautiful wedding dress, experience the joys of pregnancy with her, raise those same biological children together, and spend the rest of our lives together. But one day, I realised that the services in my own country –** the place which was meant to care for me until my dying breath – had begun their planning to ensure that my biggest dream was dead even before it had even had the chance to begin. This was the loneliest time of my life, and everywhere I turned I felt trapped.
>
> **"Accept yourself, be true to who you are…" rang in my ears. I knew that if I was "just myself" I would be accused of having "internalized homophobia" and I would be called a "bigot". I feared that if I had been open about my feelings and wants, I may have risked penalties for upsetting people in the**

LGBTIQ+ community just because I did not want to accept that identity. No, it is not because my parents were 'bigoted' either because they always told me they would love me no matter what I would choose.

I would vomit from stress. I felt that if I wanted what I wanted, I would never be able to open my mouth to anyone else in a "free" country. Eventually, I opened my bedroom window, determined to jump.

I eventually started counseling with a Christian counsellor who I met through the IFTCC [International Foundation for Therapeutic and Counselling Choice] from the United States because I did not feel safe doing counselling here in the UK.

I noticed that when I would heal from one trauma, I would look back at a particular sexual fantasy/desire and realise that it was significantly weaker, or completely gone.

I then started to become more curious about women. I noticed myself admiring their beauty and experiencing those butterflies which I'd so wished to have.

I look forward to experiencing my dream of marriage with a woman without an ounce of fear about the future. I am able to laugh heartily every day, I feel good about and in myself, and I would never take an opportunity to cut the life I now flourish in short.

I despair, however, when I think how hard it is for people who are in the position I was in. Something needs to change – they are people too and deserve to live fulfilled and happy lives just like mine. This was hard to find.

f. **Some individuals identified as LGBT and had LGBT identity experiences, but they did not find them fulfilling. They want to live the way that brings them fulfilment. (Karten & Wade, 2010) Under the MoU, may they have therapeutic help to decrease their distress, increase their well-being, explore their sexuality or gender-identity, and pursue their goals** to walk away from sexual or gender feelings or behaviours they do not want, to explore their potential for sexual or gender feelings they do want, and to live the life they desire? Is help for them conditional on a viewpoint?

17. **Where the MoU does appear to be clear is in its discrimination against the preferences, values, and beliefs of people of many of the world's major religions that are diverse from the MoU viewpoint that itself expresses a cultural worldview. People of traditional religions would like the same interventions that might be**

offered to others previously discussed in this report, to reduce distress and help them live consistently with their religious values and beliefs regarding sexuality and gender that should be respected. They do not, however, accept the MoU required viewpoint. (Richards & Bergin, 2014; Christian Ministers and Pastoral Workers, 2022; British Board of Scholars and Imams, et al., March 2024; Religious desire to resolve gender discordance: Vandenbussche, 2021**) (**More will be said about them under "XV. Growing Evidence That Researchers Who Report Harm and Researchers Who Report Benefit Are Studying Different Sub-Groups".)

a. T**he MoU affirmative approach is culturally inappropriate, can be seriously harmful for people of traditional religions, and can lead to long lasting distress and avoidance of professional services even in the face of suicidality.** (Examples: IFTCC, 2024; British Board of Scholars and Imams et al., 8 March 2024) **By contrast, professional therapy or religious ministry that is supportive of this population's preferences, values, and beliefs—supportive of their viewpoints—is perceived as helpful** (Rosik, Lefevor, & Beckstead, 2021a; 2022; Throckmorton & Wells, 2005) and has been found to reduce their distress and suicidality and improve their psychological well-being. (Pela & Sutton, 2021; Jones & Yarhouse, 2011; Sullins & Rosik, 2024)

b. **When a person's core religious self is in conflict with their sexual or gender feelings or behaviours, the MoU appears to permit them two treatment goals, both of which violate their religious beliefs:** change their primary religious beliefs about who they are to the MoU viewpoint of "who they are" on the viewpoint that doing so will supposedly increase their self-acceptance, or, in the case of gender dysphoria, have their bodies altered, contrary to their religion and life goals. Members of traditionally religious populations may believe that who they most deeply are is their religious self. Contrary to the viewpoint of the MoU, they feel who they are is not their sexual or gender feelings.

c. **If the MoU allows some people,** such as those addressed above in this report, to have therapy to decrease distress that may or may not lead to decrease in sexual or gender behaviours or the desire to engage in them, they should allow this help for people who want to live consistently with their religious, not the MoU, viewpoint without viewpoint discrimination.

18. **Regarding discordant gender identity, some detransitioners report they are not getting the help they want to resolve their gender dysphoria and mental health problems that their therapists did not treat and medical gender interventions did not help. Detransitioners have reported that professionals are afraid to see them at all.** Some detransitioners want psychotherapy to help them change their perception of who they are, to change their gender identity to identifying more closely with and being comfortable with their sex, so they can go on to the life they want, but the MoU forbids this help. (MoU, July 2024; Vandenbussche, 2021; Littman, 2021; Jenkins, 2024) It may be that, at most, the MoU allows therapists to offer help to live with gender dysphoria more comfortably. The Cass Report, by contrast, holds out hope that

psychotherapy may help core gender dysphoria. (Cass, April 2024, 11.36-11.37 on p. 150) Some gender dysphoric people who have not undergone affirmative treatments also want the same help that some detransitioners want to feel comfortable with their innate sex.

19. **The language of the MoU appears to enforce that therapy must be restricted within the boundaries of an *LGBT-identity affirmative-only viewpoint* that does not have professional consensus support and that is discriminatory, multiculturally inappropriate, and potentially harmful.**

    a. **Professionals in MoU signatory organisations have reported they feel pressure to take a purely affirmative approach to treating gender dysphoria. Dr. Hillary Cass published their concerns** in both an interim report and a final report on treatment for gender-discordant children and adolescents for NHS-England that will be discussed in more detail later. (Cass, 2022, p. 48; Cass, April 2024, p. 9)

    b. **The UK Council for Psychotherapy, a major former and founding signatory to the MoU that withdrew its signature from the MoU and its membership from the Coalition Against Conversion Therapy, confirmed that the MoU position is affirmation only for all ages.** (UKCP, April 2024)

    c. **It may be expected that an affirmation-only viewpoint for gender identity would be based on a view that gender discordance is a biologically determined condition for which biological interventions can be recommended.**

        i. The final Cass report explained, **"8.6** The search for a biological cause for gender incongruence is important to some transgender people and for some clinicians, it is seen to strengthen the justification that medical treatment is warranted." (Cass, April 2024, p. 114)

        ii. The final Cass report also explained, "This goes to the heart of some of the core controversies in this area, specifically the nature and causes of gender incongruence and dysphoria, which then has bearing on the appropriate clinical response. A failure to consider the cause, potential influences and contributory factors can lead to people taking polarised positions." (Cass, April 2024, p. 83)

    d. **The Endocrine Society's official, recently confirmed, classical definition of "sex" that they contrast with "gender" supports a traditionally religious viewpoint:**

        The classical biological definition of the 2 sexes is that females have ovaries and make larger female gametes (eggs), whereas males have testes and make smaller male gametes (sperm); the 2 gametes fertilise to form the zygote, which has the potential to become a new

> individual….the definition can be extended to the ovaries and testes, and in this way the categories—female and male—can be applied also to individuals who have gonads but do not make gametes. (Bhargava, et al., 2021, p. 221, emphasis added)

And,

> Biological sex is dichotomous because of the different roles of each sex in reproduction. (Bhargava, et al., 2021)

And,

> Thus sex differences are those caused by biological factors, whereas gender differences reflect a complex interplay of psychological, environment, cultural, and biological factors. (Bhargava, et al., 2021, p. 226)

e. **Both practitioners and clients are being placed under coercive pressure. From the affirmative viewpoint of the MoU, does helping "unhappy" gender discordant or same-sex attracted religious patients "reach a greater degree of self-acceptance" mean leading them to accept their discordant gender identity or same-sex attraction as who they inherently are and leading them to change or reject their religious beliefs? Such an approach would violate their religious beliefs, would be multiculturally inappropriate, and would be unethical.** Some affirmative therapists have been known to see this as their therapy goal with such clients. Lacking clarification to the contrary, might therapists perceive such a therapy goal as what the MoU recommends or encourages?

f. **An affirmative-only viewpoint, far from reducing distress for all, may increase distress for many, and dangerously so. One size does not fit all. For example, Christian and Muslim clients have reported** that they have experienced a therapist trying to get them to accept their same-sex attraction feelings as who they are as harmful and not affirmative of themselves. Consequences have included severe and long-lasting psychological distress after such therapy or avoidance of NIH even when suicidal. (British Board of Scholars and Imams et al., March 2024; Nicolosi, Byrd, & Potts, 2000; Throckmorton & Welton, 2005; also testimonies soon following in this report)

20. **Regarding gender dysphoria, the UK Council for Psychotherapy says people who hold a gender-critical viewpoint must not be discriminated against. It says, (UKCP, 2023)**

> Case law has confirmed that gender-critical beliefs (which include the belief that sex is biological and immutable, people cannot change their sex and sex is distinct from gender-identity) are protected under the Equality Act 2010. Individuals who hold such belief must therefore not be discriminated against.

Further, psychotherapists and psychotherapeutic counsellors who hold such views are likely to believe that appropriate therapy for gender dysphoria is exploratory psychotherapy rather than medicalised interventions.

21. **The MoU-mandated viewpoint is prejudicial and perpetuates an ideology that, it appears, may not be challenged under any circumstances. Mandating one viewpoint stifles potential for advances in clinical, multi-cultural, theoretical, and research work.**

22. **It appears the signatories of the MoU promote sexuality or gender identities that they regard as inherently preferable to other identities, contrary to their own standard, with the result that individuals who experience undesired attraction to the same sex or undesired gender discordance are not allowed to engage with practices that may assist, enhance, manage, achieve, or facilitate any level or degree of change. They potentially have no right to shape their own sexual or gender identities, feelings, or behaviours, at least if they hold an MoU-unapproved viewpoint. Such MoU-mandated sexuality and gender identity enforced by the MoU signatories is remarkable, harmful, and unjust. It requires that no individual may be assisted to exit LGBT identity or practices. It further seeks to punish any professional who assists such person-centred goals.**

23. **The MoU is viewpoint discrimination, religious discrimination and, lacking clarity, potentially is sexual preference and gender identity discrimination. Discrimination may increase distress and reduce well-being.**

24. **Sexual self-determination is part of the fundamental freedom of the individual** to live in accord with their wishes regarding sexual relationships and gender expression and to self-decide, whether or in which way and with which aim, third party persons should have any influence on this.

25. **A further difficulty with the MoU is that, in enforcing an affirmation-only treatment approach, it coerces mental health professionals to engage in professional speech and perform professional interventions against their professional judgement, ethics, conscience, or religious beliefs or else be at risk of accusations of engaging in "conversion" therapy. To be safe, therapists under such a condition may feel they must choose not to treat people who have same-sex sexuality experiences or discordant gender identity at all. Indeed, there is evidence that fewer psychotherapists have been agreeing to treat gender dysphoric patients. Gender dysphoric patients have had less access to care.** The "conversion" therapy ban of the MoU has been documented to have contributed to the backlog of gender dysphoric young people at GIDS (Gender Identity Development Service) not receiving care, which ultimately contributed to the closing of the Tavistock. We observe from the era of the MoU that a therapy ban has seriously decreased access to care for the very people the ban means to help. The "conversion" therapy ban of the MoU has resulted in very troubled young people dangerously being left for protracted stretches of time without any care.

a. **In fact, Dr. Cass has reported this** in her interim report to NHS-England, saying,

> Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people. (Cass, 2022, p. 48)

Dr. Cass says again in her final report that there is difficulty finding therapists who are willing to treat gender dysphoric young people: (Cass, April 2024, p. 202)

> **"Recruitment and training"** (Cass, April 2024, p. 202)
> **"17.20 The reluctance of clinicians to engage in the clinical care of gender-questioning children and young people** was recognised earlier in this report. Clinicians cite this stems from the weak evidence base, lack of consistent professional guidance and support, and the long-term implications of making the wrong judgement about treatment options. In addition, **concerns were expressed about potential accusations of conversion practice when following an approach that would be considered normal clinical practice when working with other groups of children and young people."**
> **"17.21 Throughout the Review, clinicians working with this population have expressed concerns about the interpretation of potential legislation on conversion practices** and its impact on the practical challenges in providing professional support to gender-questioning young people. **This has left some clinical staff fearful of accepting referrals of these children and young people."**
> **"17.22 Clinical staff must not feel that discharging their clinical and professional responsibility may expose them to the risk of legal challenge,** and strong safeguards must be built into any potential legislation on conversion practices to guard against this eventuality. This will be of paramount importance in building (as opposed to diminishing) the confidence of clinicians working in this area. Any ambiguity could serve to further disadvantage these children and young people rather than support them."
> **"17.23** Clinicians are being asked to work within a **highly emotive and politicised** arena. This, coupled with concerns about the weakness of the evidence base and a lack of professional guidance, **has impacted on the ability of the new services to recruit the appropriate multi-disciplinary workforce."**

And yet again,

> Responding to changing social and cultural expectations, political interference, and regulatory scrutiny, they [clinicians] said, made for a difficult working environment.
> (University of York, 2024, Appendix 3: Qualitative research summary: Narrative accounts of gender questioning, in Cass, April 2024, p. 9)

b. **In the case of same-sex attraction or behaviour, as in the case of gender dysphoria, the International Foundation for Therapeutic and Counselling Choice has heard from therapists who are afraid to help these individuals as well,** especially if they desire to explore their potential to change same-sex attraction feelings or behaviours. Also, individuals, such as in the following testimonies, have reported to the IFTCC that they cannot find help. (IFTCC, April 2024)

> **Male, 35, England:** "I sought numerous counselling with the NHS and a few churches, but **no one could really address it. Most were even scared to deal with it."**
>
> **Male, 31, England: "I felt completely unable to approach the NHS** for help with these issues, including depression which I knew to be related, because their answer would be that I should embrace my same sex attractions which is contrary to what I wanted to do. As a result, I felt trapped and said to myself that I would 'take this issue to the grave'. I no longer wanted to be alive."
>
> **Male, 33 England:** "After the break-up, **I knew immediately that the NHS would not help** with this specific issue due to the cultural norms around LGBT in the UK, which is why I sought help from [redacted] at Core Issues Trust and IFTCC. [redacted] was able to give me some wise counsel around how to deal with relational problems and he helped me to connect with other people on a similar journey."
>
> **Female, 35, England: "How can the government not allow help for people like me??** Is it because they think we don't exist? I know our voices are being silenced and I don't feel heard, I feel attacked and singled out for my belief because it goes against LGBTQ community."

26. In summary, the MoU in effect polices speech and, in addition, thoughts, values, beliefs, ethics, life goals, preferences, sexual feelings, sexual behaviours, gender identity, gender expression, many religions, and many cultures. Viewpoints on these should not be a test for obtaining effective care. To justify enforcing viewpoint discrimination with such deep and wide-reaching effects, there should be incontrovertible scientific evidence.

III. NO SUPPORTING RESEARCH OFFERED BY THE CURRENT MoU AND LIMITED RESEARCH FROM VERSION 1 AND RELATED DOCUMENTS REGARDING SEXUALITY AND GENDER IDENTITY CHANGE

27. The current MoU, Version 2, offers no original research or research review of its own or indeed any research references in support of its viewpoint or even references at all. Versions published in 2017, 2019, 2021, 2022, and 2024 have all suggested conducting research "if funded".

28. The original version of the MoU (2015) had 7 footnotes containing 6 references to any original research or research review. These do not provide incontrovertible scientific evidence that would justify the viewpoint discrimination and prohibition of therapy under the MoU.

a. **In one study referenced in the original MoU, researchers surveyed a representative sample of mental health professionals** who were members of the British Psychological Society, the British Association for Counselling and Psychotherapy, the United Kingdom Council for Psychotherapy, and the Royal College of Psychiatrists. **Among the 222 members who actually had professional experience (17%, or 1 in 6 psychotherapists, counsellors, and psychiatrists) in assisting "at least one client/patient to reduce or change his or her homosexual or lesbian feelings," 72% supported it and offered some details about their cases.** Justifications given for therapy with this client goal were client self-determination, [opposite-sex] marriage, sexual preference was unsatisfying because of childhood sexual abuse that possibly impacted on sexual preference and with trauma resolution the client may change preference, physically damaging to health, and value systems as a key issue ("e.g. family, religious, social or ethical values"). **The authors acknowledge that "behavioural treatments now appear to be uncommon", and by contrast "therapists continue to provide other talking therapies to help clients to change."** (Bartlett et al., 2009, p. 7)

b. **The next three research references in the footnotes of the original MoU are said to be reviews of change-allowing therapy by professional bodies.** The 2015 MoU stated, "Several professional bodies have reviewed the evidence around conversion therapy and concluded there is no good evidence that it works, while there is evidence that it has the potential to cause harm."

c. **The first of these** was a report of the "American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation" (APA Report, 2009). **The APA Report conducted no original research. It is a research review, and the research it reviews pertains only to sexual orientation and not to gender identity or expression. This reference is relevant as a potential scientific support for the MoU. I will review it in this report.**

d. **The next professional body review referenced in the 2015 MoU is the "Conversion Therapy Consensus Statement" (2014). The consensus statement says it was "prepared by the UK Council for Psychotherapy** with the support and assistance of the British Psychoanalytic Council, the Royal College of Psychiatrists, the British Association for Counselling and Psychotherapy, the British Psychological Society, the National Counselling Society, Pink Therapy, Stonewall, PACE and Relate". This document supports its censorship of change-allowing therapy in two main ways.

    i. **First, it says, "As homosexuality is not an illness, it is both logically and ethically flawed to offer any kind of treatment." The signatories soon contradict themselves, however.** Do the UKCP and its supporting organisations actually hold to a principle that it is unethical to help someone change something that is unfulfilling to the individual but is not an illness? There are numerous examples of professionally approved topics of treatment that are not considered to be illnesses. Marital dissatisfaction is not a mental disorder. Do the UKCP and supporting organisations consider marriage counselling unethical? What about counselling for bereavement or employment dissatisfaction? **In fact, the UKCP Conversion Therapy Consensus Statement itself says, "People visit therapists for all sorts of different reasons. Bereavement, employment or relationship difficulties are just some of the common reasons why people seek specialist support." More issues that are not considered pathological but may benefit from "specialist support"** for significant stress include unplanned pregnancy and difficulties due to deeply held beliefs, for example, that divorce or abortion is wrong. **The MoU itself accepts "treatments" for "trans patients", and in the MoU the "signatory organisations agree" that "gender identity" is not "a mental disorder."** (MoU July 2024, version 2, revision A) Treatment for trans-identified patients may include **attempts to make changes to the appearance of the person's sex, an inborn and immutable trait. These treatments may be dramatically harmful**—suppressing or destroying reproductive systems, inducing hormonal states typical of disease states, increasing risks for strokes, blood clots, heart attacks, and cancers, and potentially shortening life. (van Zijverden et al., 2024; Dhejne et al., 2011; Laidlaw, Cretella et al., 2019; Laidlaw, Van Meter et al., 2019; Laidlaw & Jorgenson, 2014; Glintborg et al., 2022) **It appears that the signatories of the MoU do indeed accept treatment for conditions they do not consider to be disorders.**

    ii. **Second, the "Conversion Therapy Consensus Statement" (2014) said, "Randomised controlled trials are the scientific gold standard for assessing the effectiveness of treatments. There are no randomised trials of conversion therapies." By this standard, the authors also discredit therapies they prefer.** The consensus statement referenced 2 research reviews that I will address. (Serovich et al., 2008 that I will

address shortly and APA Report, 2009, that I will address at appropriate points in my report, primarily at "XII. Challenges to Change-Allowing Therapy")

a. **But does the UKCP actually forbid therapies that do not have randomised controlled trials to prove their efficacy? I am aware of no professional organisation that does so.** The subtle shift of burden of proof reveals the bias here. **For all other therapies, presence of evidence proving a therapy is ineffective is necessary to recommend discontinuing it. For change-allowing therapy, the standard is reversed. Lack of randomised, controlled trials proving such therapy *is effective* is treated as though it is scientific evidence that such therapy is *ineffective*. Absence of evidence is not evidence.** There is not research evidence that meets scientific standards that proves change-allowing therapy is ineffective.

b. **The Coventry Report (Jowett et al., 2021, p. 52) commissioned by the UK government accepted that, for practical and ethical reasons, it would be difficult to conduct randomised controlled trials for sexual orientation change efforts**. One expectation might be that, to conduct randomised controlled trials of change-allowing therapy, researchers may need to randomly assign some individuals who have same-sex attraction feelings or behaviours to change-allowing therapy and others to LGB-identity-affirmative therapy, no therapy (wait list), or placebo (an inert intervention that a participant may believe is potentially effective therapy of some kind) regardless of the client's preference, goals, or needs. Attempting to give either affirmative treatment or change-allowing treatment to a person who does not want it would violate the fundamental ethical principle of client autonomy and be unethical.

c. **There are now randomised controlled trials (RCTs) that have demonstrated reduction in same-sex partners, an RCT demonstrating increased opposite-sex attraction and decrease in same-sex attraction, and RCTs that have demonstrated reduction in specified sexual attractions regardless of whether they were directed toward the opposite or same sex.** (More discussion of these studies under "X. The Best Available Research Supports the Safety and Effectiveness of Change-allowing Psychotherapy".)

d. **For perspective, there are some randomised controlled trials that have found affirmative therapy was no more effective than standard therapy and therapy based on the minority stress theory was not more effective than not having the therapy.** (Discussion and references at "XII. Challenges to Change-Allowing Therapy")

2. **The UKCP-led consensus statement further said about research methods, "Recent systematic reviews of the evidence for conversion therapy suggest that studies which have shown it to be successful are seriously methodologically flawed." Again, by this standard the authors also discredit therapies or services they prefer.** The consensus statement referenced research reviews dated 2008 (Serovich et al.) and 2009 (APA Report). **It omitted a comprehensive review dated 2007 that reported that no studies at all for any therapies or services for LGBT-identified people were randomised trials, and all had significant methodological flaws.** (King et al. 2007**) This assessment would appear to apply also to services or therapies the signatories to the UKCP consensus statement uncritically accept.**

3. **The APA Report, that the UKCP consensus statement referenced, said it could not draw conclusions about either "sexual orientation change efforts" ("SOCE") or affirmative therapy from research, because research on SOCE had methodological flaws and research on affirmative therapy was non-existent.** (I will review the APA Report at other points in this report, primarily at "XII. Challenges to Change-Allowing Therapy").

4. The final reference in the UKCP consensus statement was to a research review by Serovich et al. (2008).

a. **Serovich and colleagues reported a systematic research review** of two types of therapy they said had been offered with a goal of decreasing same sex attraction or behaviour— namely "reparative therapy" and "aversion therapy".

b. **The authors concluded the methodology in research studies reporting successful "reparative therapy" did not meet the criteria of Serovich and colleague's day, calling into question the research measures. As I have said, however, a 2007 research review (King et al.) leveled the same charge against all research on**

services for LGBT-identified people, presumably including services and therapies the Consensus Statement" signatories uncritically accepted.

c. **The Serovich review also said "reparative therapy" lacked a theoretical foundation when the review was published in 2008. A definitive theoretical work on the reparative approach to therapy was published the next year, 2009, by Joseph Nicolosi, Sr., *Shame and Attachment Loss: The Practical Work of Reparative Therapy*.** Serovich and colleagues misused the term "Reparative Therapy®" to stand for all change efforts, which usage is now against federal trademark law in the U.S.)

d. **Serovich et al. said they reviewed studies of "electroconvulsive shock therapy", a method they said was used in an effort to alter same-sex sexuality. (p. 230) *Electroconvulsive* shock therapy, however, is a medical treatment used for patients suffering from catatonic states (Luchini et al., 2015) or from severe depression that has not responded to other treatments (Li, Yao et al., 2020). The research references listed for "electroconvulsive shock therapy" in the Serovich review clarify that what the authors actually reviewed was instead behaviouristic aversion therapy used when behaviourism was a mainstream school of psychotherapy and used behaviouristic *electro*-shock therapy, which Serovich et al. acknowledged had already been abandoned from use by the time of their review. (p. 230) It is not clear why Serovich et al. altered the name for this approach, whether they really did not know the difference or for effect.**

e. The Serovich et al. review could have led to a conclusion in 2008 that no conclusion could be made about change-allowing therapy, but then they would have needed to come to the same conclusion for therapies the reviewers accepted.

iii. **In summary, the signatories of the Conversion Therapy Consensus Statement could have concluded in 2014 that no conclusion could be made about change-allowing therapy, but then they would have had to draw the same conclusion about therapies they preferred.** The signatories in fact do accept therapies for conditions or concerns they do not consider to be mental illness and therapies for which there are

no randomised controlled trials and for which research has methodological flaws. (King et al., 2007)

e. The third of the three references to a critique of change exploratory therapy by a professional body that the 2015 MoU referenced was a Royal College of Psychiatrists (RCPsych) paper, "Psychiatry and LGB People". This paper made a now-outdated claim that same-sex sexuality is biologically determined. Otherwise, it appeared to make arguments similar to those addressed above.

i. I will take "Psychiatry and LGB People" to be a shortened title for the RCPsych paper, "Response to the Pilling Commission (2012) and the Church of England Listening Exercise on Human Sexuality (2007): Psychiatry and LGB People". (I did not find a paper with exactly the short title as given in the 2015 MoU footnote, and the provided link no longer appeared to be functional.)

ii. **In this paper, the RCPsych said sexual attraction is biologically determined**. "It would appear that sexual orientation is biological in nature, determined by genetic factors…and/or the early uterine environment…." **The next RCPsych paper I discuss corrects this view of biological determinism.** The present paper under discussion went on to say, "being gay, lesbian or bisexual is compatible with normal mental health and social adjustment", and, at the same time, "LGB people experience a greater than expected prevalence of mental health and substance misuse problems". It also said, "There appears to be considerable variability in the quality and durability of same-sex, cohabiting relationships". It attributed greater prevalence of mental health problems and "a considerable amount of the instability in gay and lesbian partnerships" to lack of societal affirmation. It predicted greater societal affirmation will improve these. This is the minority stress theory, and I will later review research by the originator of the theory and colleagues from which they concluded that the best evidence over 50 years has not supported the theory. (Meyer et al., 2021, discussion at "XIV. More Reasons Why It Cannot Simply Be Assumed That Change-Allowing Therapy Causes Suicidality")

iii. **The RCPsych paper accepted that harmful (behaviouristic aversive) methods that were used in the 1960's and 1970's are "historical".**

iv. **It did not apply the same methodological standards it required of change-allowing therapy to studies it relied on to claim harm, nor did it appear to consider applying the same standards to any potential research on LGB-identity-affirmative therapy. It appears the Royal College of Psychiatrists applied its standards of scientific methods inconsistently to studies with outcomes it did not prefer compared to studies with outcomes it preferred.** The paper dismissed change-allowing therapy because, it said, there are no randomised controlled

trials for sexual orientation change efforts, and it found methodological flaws in 2 studies that reported successful change.

v. **In summary, the RCPsych appeared to make the now-outdated claim that same-sex sexuality is biologically determined, which it has since rescinded, acknowledged aversive methods are historical, and otherwise added no new arguments to those I have addressed above.** It said therapy that attempts to change sexual orientation "can be deeply damaging", citing Shidlo and Schroeder, 2002, which I will discuss later (at "XII. Challenges").

f. **Another professional body's research review to which the MoU Version 1 also referred is the "Royal College of Psychiatrists' Statement on Sexual Orientation" (RCPsych, 2014).** The purpose for the reference was not to provide a research review, but it does do that.

i. **As did the UKCP consensus statement, this statement relied on the the Serovich review (2008) that I have critiqued above and on the APA Report (2009)** that said sexual orientation change efforts have "serious methodological flaws", and "there is evidence they are potentially harmful". I will critique the APA Report later, but I note here briefly that the APA Report also said it had no research that supported the effectiveness or safety of LGB-identity-affirmative therapy. (APA Task Force, 2009, p. 91) It also said no research that claimed harm from sexual orientation change efforts met its scientific standards. (p. 42, no valid causal evidence of harm)

ii. **For evidence of harm, the RCPsych Statement on Sexual Orientation also referenced a news article (not research) (BBC News, 2013) about Alan Chambers, a president of Exodus International, an umbrella organisation of religious support organisations for adults who experience same-sex sexuality and desire to live consistently with their religion. It was reported that he said religiously mediated change efforts do not work. Chambers' personal statement is contradicted by 2 peer reviewed longitudinal studies of Exodus participants.** One of these studies was a prospective, longitudinal, naturalistic, quasi-experimental study of members of organisations under the umbrella of Exodus. The study found that the majority of Exodus participants, 53%, substantially changed to exclusively opposite-sex attraction or significantly decreased their same sex attraction. Such change would enable these participants to live in an opposite-sex relationship or be abstinent more easily and enjoyably, thus achieving their goals. Some participants were continuing in process, and some did not change. Psychological effects were only in the improved direction. (Jones & Yarhouse, 2011) In an earlier longitudinal Exodus study, participants reported significant increase in opposite-sex attraction, and 71% reported successful abstinence from

same-sex behaviour through a religiously mediated path or through this religious path plus a course of professional psychotherapy of 38 sessions or more (amounting to 9 months or more if sessions were weekly). Change was associated with improved mental health. (Schaeffer et al., 2000; Schaeffer et al., 1999) Chambers' opinion was contradicted by this body of research and did not represent the perspective of member organisations of Exodus. As a result, they left Exodus to reorganise, many under the new umbrella organisation, Restored Hope Network, that continues robustly to this day. (https://www.restoredhopenetwork.org) Chambers was left with an empty shell of an organisation and little choice but to close it. Essentially, the members closed him down. While Chambers' opinion may please some activists, it is not scientific evidence and was already contradicted at the time by peer reviewed research specifically on Exodus members. I cannot evaluate the source of Chambers' viewpoint. I deduce that he had not experienced change himself and believed no changed. He is not alone in this perspective. I note a study of same-sex attracted young adults in which 63% of females and 50% of males experienced some change in their sexual attraction. Participants who had experienced change were more likely to believe sexuality was changeable, and participants who had not experienced change were more likely to believe others do not change either. (Katz-Wise & Hyde, 2015. More discussion of these longitudinal Exodus studies is at "X. The Best Available Research Shows Change-Allowing Psychotherapy for Same-Sex Sexuality Improves Mental Health and Is Effective")

iii. **The RCPsych statement also referenced another news article as evidence of harm (Harris, 2012), this one about Robert Spitzer who had led the committee that took homosexuality out of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in 1973. Thirty years after that decision, Spitzer (2003a; 2003b; Zucker, 2003) published a research article, "Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation." The news article was about an aging, frail, and ill Spitzer publishing a statement that he now reinterpreted as unreliable his 2003 study finding that some people changed, because it used self-report.** This occurred after an activist journalist visited the 80-year-old Spitzer who was suffering from Parkinson's and told him that, as a result of Spitzer's study, the journalist tried change-allowing therapy and did not change. The journalist said he felt harmed and told Spitzer his study harmed many people. Emotionally distressed, Spitzer approached the editor of the journal where the article had been published and asked to retract it. **The editor, Kenneth Zucker, said there was no scientific or ethical basis for retracting the study and refused. Spitzer's article has not been retracted, and it continues to**

be available to this day. The journal editor allowed Spitzer to publish a letter expressing regret that he published this study and saying he now reinterpreted the results as unreliable because he used self-report. (van den Aardweg, 2012; Spitzer 2012; Armelli et al., 2012) **In Spitzer's original research article (2003), he had already taken into account that he relied on self-report and had addressed in detail the evidence that led him to judge the participants' reports to be reliable.** His published article said, "For many reasons, it is concluded that the participants' self-reports were, by-and-large, credible and that few elaborated self-deceptive narratives or lied." If use of self-report is sufficient to discredit altogether a study and a therapy approach, then endless library shelves of psychiatric and psychological research journals throughout the world would have to be largely emptied. Studies and treatments would have to end that the UKCP, RCPsych, and many more rely on and favour. Any research or treatment that was in developing stages would be forbidden.

iv. **The RCPsych's "Statement on Sexual Orientation" did acknowledge that same sex attraction is not simply biologically determined but also is influenced by postnatal environmental influences. A view that sexual attraction is biologically determined has been used by some as a reason to argue that sexual attraction cannot change, hence cannot change through therapy.** The RCPsych Statement said, "The Royal College of Psychiatrists considers that sexual orientation is determined by a combination of biological and postnatal environmental factors." The College hereby corrected its document, the "Response to the Pilling Commission (2012) and the Church of England Listening Exercise on Human Sexuality (2007): Psychiatry and LGB People", that had said sexual attraction is biologically determined.

v. **The RCPsych "Statement on Sexual Orientation" seemed to say that, with some exceptions, most people's sexual attraction is permanently set as either "gay" or "straight".** If that were true, then sexual attraction could not change through life experiences such as change-allowing therapy. The Statement says, "It is not the case that sexual orientation is immutable or might not vary to some extent in a person's life. Nevertheless, sexual orientation for most people seems to be set around a point that is largely heterosexual or homosexual."

vi. **Michael King, an openly gay-identified-scholar who said he wrote from the perspective of "a gay psychiatrist", however,** who oversaw the production of the RCPsych's submissions to the Church of England's Pilling Commission (2012) as well as various RCPsych position statements on sex and gender, came to see that position as more politically useful than scientifically accurate. He came to see sexual attraction as being on a spectrum, fluid, and not necessarily

lasting lifelong or who a person is. In an interview in the London edition of the RCPsych e-newsletter, *The Psychiatric Eye*, **King said,**

> The other important thing is to understand much more about sexual orientation. It's quite obvious that it's much more of a spectrum than we've heretofore thought**. It's a sort of political thing: "gay", "straight", all that stuff. What appears to be coming from most recent studies with young people is there's a certain flow and flux along a spectrum.** It's much more likely that sexuality is on a spectrum, as most things in nature are. It would be really helpful to understand that more. **To understand that many people have sexual responsiveness to the same or other sex, and it doesn't classify them as being a certain type of person for their lives."** (Shah & King, 2019, p. 18)

vii. **In summary, the RCPsych "Statement on Sexual Orientation" (2014) rescinded its previously invalid claim that same-sex sexuality is biologically determined but added a new invalid claim that sexual attraction is permanently set for most people. It argued the existing research evidence for change-exploring therapy had flaws, then used statements of opinion and reinterpretation (not research evidence) to make its own arguments.** (I will discuss research on same-sex sexuality causes and change at "IV. Same-Sex attraction and Incongruent Gender Identity—Not "Born That Way"; "V. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan".)

29. **The RCPsych "Statement on Sexual Orientation" (2014), the RCPsych paper, "Psychiatry and LGB People", and the MoU 2015 addressed only change-allowing therapy for same sex sexuality. The RCPsych did address change-allowing therapy for *gender discordance* in 2018 in a position statement, "Supporting Transgender and Gender-Diverse People".**

    a. A notation that was later placed on it stated, "April 2023 update: A review of this publication is planned and will take place in due course." An "RCPsych Interim Statement Regarding Transgender Health" with no date presents no research on any kind of treatment.

    b. **The 2018 version of the position statement, "Supporting Transgender and Gender-Diverse People", gave two research references on "conversion therapy".** The first reference was to a discussion of research (Mizrock & Lewis, 2008) that gives a reference to a position statement that gives no references including no references to research. The second reference was to a research review. (Wright, Candy, & King, 2018) It found a limited number of case studies, most of which reported the patients successfully *resolved* gender discordance through psychosocial support, but their methodology was weak.

A review based on these case studies could conclude that there is insufficient evidence to draw any conclusions. The reviewers then stated with certitude, "What is known, however, is that TGD [transgender and gender diverse] *affirmative* practices are associated with positive mental health outcomes". (Wright, Candy, & King, 2018, p. 11, bold and italics added) They based this on a single study of 8 participants with a 3 month follow up reporting depression decreased and there was no significant change in coping skills. (Austin, Craig, & D'Souza, 2018, abstract) Here is surely a breath-taking double standard for when research can be taken as conclusive. The bias is all-the-more remarkable in that the research reviewers entirely omitted a far more rigorous study available at the time, a prospective, 30-year longitudinal, controlled study of an entire population cohort in Sweden that underwent hormone and surgery gender treatment. This study found increased rates of psychiatric hospitalisations, increase in deaths from cancers, heart attacks, and strokes, and a suicidal rate it said was 19 times higher than for matched peers in the general population, a study that, even though not perfect, was methodologically orders of magnitude superior. (Dhejne et al., 2011)

c. **In summary, this RCPsych 2018 position paper and its references did not furnish meaningful evidence to support the MoU and its profound discrimination.** It's only research reference said research for change-allowing therapy was methodologically flawed, then offered a weak and far more flawed study in support of affirmative gender practices it uncritically accepted.

30. **A final research reference in the 2015 MoU footnotes was to the British Psychological Society "Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients". (Shaw et al., 2012) It appears to provide no research on client-initiated, contemporary, change-allowing therapy for same-sex sexuality or discordant gender identity. It furnishes no research for the MoU that justifies its position. The guideline referenced only irrelevant studies** as follow:

    a. **It acknowledged aversive methods were historical by 1987**.

    b. **It gave one 1973 reference on aversive behaviouristic methods that it acknowledged were already outdated well before the BPS review.** (BPS, 2012, pp. 71-72; Barlow, 1973).

    c. **It referenced 4 publications on gender issues or therapy for transgender-identified people that give no indication of an attempt to change gender identity.** (Meyer et al., 2001; Lawrence, 2003; Seikowski, 2007; Loewenberg & Krege, 2007) The purpose of therapy could have been to confirm the diagnosis and its persistence or to support the patient through medical interventions. One article (Lawrence, 2003) was a study of sex surgery, not of "counselling and psychotherapy to 'cure' transsexuality" as the guideline suggested. The article said, "Greater amounts of preoperative psychotherapy were associated

with poorer subjective outcomes, although this could be due to participants with more severe psychological problems undergoing more psychotherapy, rather than psychotherapy itself causing negative outcomes." The article did not say preoperative (or postoperative) therapy was to "cure" transgender identity. The argument from the combined references seemed to be that psychotherapy should not be a prerequisite for medical gender interventions (BPS, 2012, pp. 24-26).

31. **The BPS had published more recent "Guidelines" (2019) that appears to offer no new references to research to support its opposition to change-allowing therapy. Some more recent publications of the MoU Version 2 referred readers to these guidelines for training purposes.** It refers back to the MoU version 2, to the earlier BPS Guidelines (Shaw et al., 2012), and to the previously mentioned research review published by King et al. (2007) that found all research on any therapies and services in general offered to LGBT-identified people had methodological limitations. The BPS published the "Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity, for Adults and Young People (Aged 18 and Over)" in 2019. The 2021, 2022, and July 2024 versions of the MoU now refer signatories to guidelines for training published by any signatories. (MoU 2021; 2022; July 2024)

32. **Not referenced in any version of the MoU, but a relevant document, is the UK Council for Psychotherapy (UKCP, no date), "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." It offered one reference on change-allowing therapy that appears to be an out-of-print book**, and that reference appears to have pertained only to sexual orientation and not to gender identity.

33. **A Memorandum of Understanding on Conversion Therapy on the Island of Ireland essentially makes the same statements as the UK MoU and offers no research references**.

34. **The APA 2009 Report referenced in the original 2015 MoU, therefore, may come closest to being research on which censoring change-allowing therapy might be scientifically based in the MoU. The APA Report said it was "built" on what it claimed was a "key" scientific finding, that only sexual identity (self-label) changes, but sexual orientation (meaning sexual attraction in this APA report, p. 30) does not change through life events (pp. 63, 86, also 54) (so it is unlikely to change through therapy). The view that sexual orientation or attraction does not change is usually based on a view that sexual attraction is largely or solely biologically determined.**

35. **In the coming sections of my report, I begin with a discussion of evidence on the extent of biological influences on same-sex sexuality and gender dysphoria or discordance (section IV). Next, I present research that evaluates what the APA Report claimed about sexual attraction change through life events (section V).** The APA Report did not address discordant gender identity, but the MoU does, so I next present research on gender dysphoria change through life experience (section VI) and

evidence for treatable psychological causes of gender discordance (section VII). With this background, I go on to critique affirmative treatment for gender dysphoria or discordance the MoU accepts (section VIII). I then progress to ethical guidelines (section IX) and research for improved mental health and sexual attraction and behaviour change through therapy (section X) and research for psychotherapy that has the intent to resolve gender dysphoria (section XI). Following these, I address challenges that have been brought regarding change-allowing therapy in the APA Report (section XII) and otherwise (sections XXII, XIII, XIV), growing evidence that shows researchers who report harm and researchers who report benefit are studying different sub-groups (section XV), and professional organisation support for change-allowing therapy (section XVI). I end with comments on the MoU (section XVII) and my conclusion (section XVIII).

IV. SAME-SEX ATTRACTION AND INCONGRUENT GENDER IDENTITY —NOT "BORN THAT WAY"

36. **The question, "what are biological or other causes of same-sex sexuality and gender incongruence?" is a sensitive one, because some people have come to terms with these experiences by a viewpoint** that these feelings are biologically determined and who they *are*. Other people have come to terms with these experiences by a viewpoint that these feelings are not simply biologically caused and are feelings they *have* and *not* who they *are*.

37. **If same sex attraction and gender incongruence are simply biologically determined and therefore "innate" traits (as claimed, for example, in the Banning Conversion Therapy Government Consultation, Gov.UK, 2021, p. 16, and the Faith and Sexuality Survey Executive Report, Ozanne Foundation, 2018, Bishop's forward) then efforts to change them would appear unlikely to succeed. If these experiences, on the other hand, develop in part for some or largely for all from psychosocial experiences, the question of efforts to change remains open to explore further.**

38. **The final Cass report commissioned for NHS-England recognizes that the view of whether *gender incongruence or distress* has a biological cause goes to the heart of the controversies over the appropriate clinical response. It is likewise true that whether *same-sex sexuality or distress concerning it* has a biological cause goes to the heart of the controversy over what appropriate clinical responses may be, although sexuality was not the subject of the Cass Review. The final NHS report says with regard to gender (as previously quoted),**

> **"8.6 The search for a biological cause** for gender incongruence is important to some transgender people and for some clinicians it is seen to strengthen the justification that medical treatment is warranted." (Cass, April 2024, p. 114, emphasis added)

> "This goes to **the heart of some of the core controversies** in this area, specifically **the nature and causes** of gender incongruence and dysphoria, **which then has**

bearing on the appropriate clinical response. (Cass, April 2024, p. 83, emphasis added)

39. This section of this report now presents research that investigates whether same-sex sexuality and incongruent gender identity are simply or largely biologically determined.

40. Genetic influences on same-sex sexuality: Gene research and research on twins do not make a case that same-sex sexuality is determined largely or solely by genes.

41. The largest-ever gene study was published in 2019 on nearly half a million participants (477,522 from the United Kingdom and the United States plus 15,142 from the United States and Sweden for replication analyses) by more than 20 researchers in universities and research institutes in 6 countries. They analysed gene variations ("variants" or "markers" which are the parts of DNA that vary from person to person and appear in at least 1% of the population) that differ between people who, as a group, have engaged in same-sex sexual behaviour and those who, as a group, have not engaged in same-sex sexual behaviour. The researchers concluded the following (Ganna et al., 2019a, 2019b).

a. **The study's findings on same-sex behaviour also apply to same-sex attraction and same-sex orientation identity, because all these sexuality traits correlate with similar gene variants** (2019a, p. 4, 6) **according to multiple data sets the researchers used for replication.** (2019a, p. 1-2)

b. **There is no single "gay gene". The researchers reported, "We can therefore say with confidence that there is neither a single genetic determinant of, nor a single gene for, same-sex sexual behaviour or sexual orientation."** (Ganna 2019b) Researchers said **the findings did not confirm that previously hypothesized gene variants on the "X" sex chromosome correlated with same-sex sexuality**. (Ganna 2019a, pp. 3-4)

c. **There are multiple genetic variants associated with same-sex behaviour. "Each marker has a very small effect individually — that is, each contributed very little to a person's sexual behaviour. This is not unusual for complex human outcomes. Common genetic variants often contribute only a tiny amount to the variation in the overall outcome."** (Ganna 2019b, bold added)

d. Development of same-sex behaviour is influenced somewhat by genes but largely by a person's life experiences in their environment. The researchers explained,

> ***"*Behavioural traits, like sexual behaviour and orientation, are only partially genetic in nature….they are also shaped in large part by a person's environment and life experiences**….Our genetic findings in no way preclude the **additional influences of culture, society, family, or individual experiences, or of non-genetic biological influences,** in the

development of sexual behaviour and orientation." (Ganna et al., 2019b, emphasis added)

e. **Many gene markers associated with having engaged in same-sex behaviour are linked to personality traits, health risk behaviours, and psychiatric disorders.** (Ganna, et al., 2019a, p. 6; 2019b) **These *are not* directly related to sex.**

   i. Personality traits: externalising behaviours such as smoking, cannabis use, risk-taking, and the personality trait "openness to experience;" loneliness. (Ganna 2019a; 2019b)

   ii. Psychiatric disorders: depression and schizophrenia (in both sexes) and bipolar disorder (higher in females). (Ganna 2019a, p.5; 2019b; for depression see also Zietsch et al., 2012).

   iii. A possible exception to these links being genetic in nature is that some traits may be linked with one another because they are commonly associated with environmental experiences, researchers cautioned. For instance, we know that individuals who have experienced same-sex attraction or behaviour or who identify as LGBT are at greater likelihood of having suffered adverse childhood experiences such as childhood sexual abuse, and childhood sexual abuse is known to be associated with depression. (McLaughlin et al., 2012; Eskin et al., 2005; Bedi, Nelson et al., 2011; Fuller-Thomson et al., 2016) A study using the highly regarded Australian community twin registry found genetic factors accounted for 60% of the association between nonheterosexual preference and depression, and childhood sexual abuse and risky family environment also each accounted for some of that association. (Zietsch et al., 2012)

      1. **Related to the findings of Ganna et al., a pair of large, rigorous studies both found psychological distress (depression and anxiety) had a large causal effect for same-sex attraction, and simultaneously same-sex attraction had a large causal effect for psychological distress.** The first of these studies also found *causal* effects from depression, anxiety, and risky behaviour leading to same-sex attraction, and, simultaneously, *causa*l effects from same-sex attraction leading to depression, anxiety, and risky behaviour. (Finland: Oginni et al., 2022; UK: Oginni et al., 2023) These findings appear to be consistent with the findings from the largest-ever gene study (Ganna et al., 2019a) that genes associated with depression and risky behaviour are also associated with same-sex behaviour. One of the studies finding bi-directional causal effects was from a UK cohort in a replication study to the Finnish cohort study. These studies employed multiple methods: gene correlations, twin

correlations, questionnaire responses accessed retrospectively from adult participants, and questionnaire responses accessed prospectively from their mothers. Hence, these are very exceptionally strong studies. (Finland: Oginni et al., 2022; Oginni et al., 2023)

2. Although gene variations can come from fresh genetic mutations, genes generally are inherited from parents, and therefore, if individuals have these genes, their parents do also. It is possible that some of these genes, such as genetic predisposition to mental health disorders or risky behaviour, could have an influence on parent-child relationships, family function, and life experiences in the childhoods of individuals who developed same-sex attraction or behaviour, and these experiences could be mediating causal influences in that development. This would be an example of potential interaction of genetic and psychological influences on development of same-sex sexuality.

f. **Some gene markers *are* related to sex. They may influence but do not determine the development of same-sex behaviour.**

i. Might some boys be born less masculinised? One replicated gene variant "is linked to male pattern balding and is nearby a gene…relevant to sexual differentiation…." This "strengthens the idea that sex-hormone regulation may be involved in the development of same-sex sexual behaviour" in men. (Ganna, et al., 2019a, p. 6) Less masculine traits in a boy do not equal same-sex attraction feelings or behaviour. They could, however, lead to social experiences that some have felt led to their same-sex attraction or behaviour. Some men who benefitted from change-allowing therapy have said they felt their fathers had difficulty from the start with emotionally connecting with them or accepting them, if the fathers felt these boys were less masculine in the stereotypical sense, and some boys felt their fathers bullied them, perhaps in an effort to make their sons more stereotypically masculine. Some have said older brothers, male peers, and also female peers saw them as less masculine and rejected or bullied them. **These clients felt the *reactions of others to* their less masculine or more feminine traits, in other words *stigma*—and not atypical gender traits per se—*contributed to the development of their same-sex attraction or behaviour*.** (Nicolosi, 2009, example p. 41)

ii. Might a miss-smelling tendency be a contributing factor? Another replicated gene variant "is strongly linked to several genes involved in olfaction." This "missense variant…has been reported to have a substantial effect on the sensitivity to certain scents" (Ganna 2019a,

p. 4). A "link between olfaction and reproductive function has previously been established" (p. 6).

g. No genes linked to physical traits were associated with whether or not individuals engaged in same-sex behaviour. **The physical traits not found to be genetically linked were height, waist-to-hip ratio, birth weight, and 2D:4D digit ratio (second finger length to fourth finger length ratio).** (Ganna 2019 a, Figure 4)

h. **The researchers used multiple methods to identify genes associated with same-sex behaviour and to estimate the degree to which genes contribute to engaging in same-sex behaviour**. In addition to comparing genes in people who had or had not experienced same-sex behaviour, the researchers also compared same-sex behaviour in people who were or were not genetically verified close relatives.

i. **Broad sense heritability— "the percentage of variation in a trait attributable to genetic variation"—was estimated at 32.4%**. (Ganna 2019a, p. 2) But the genetic variants the researchers identified (discussed above) only account for about 8 to 25% of the genetic factors, not the full 32.4%. The remaining genetic variants each have such small associations to same-sex behaviour, less than 1% each, that even a study of this magnitude could not find them. The researchers said, "When we analyse all common genetic markers together, they capture between 8 and 25% of the individual differences in same-sex sexual behaviour. These results suggest that more markers will be discovered with larger sample sizes." (Ganna et al., 2019b)

j. Genes that were associated with the *proportion* of an individual's sex partners who were same-sex (25%) were even lower than genes associated with whether an individual *ever* engaged in same-sex behaviour (32.4%). (Diamond, 2021)

k. Even if someone had *all* genes variants associated with same-sex behaviour, these genes would not predict that the person would develop same-sex behaviour, "orientation" meaning attractions, or orientation identity.

> **"It is not possible to predict or identify someone's sexual behaviour or sexual orientation from their DNA…. These results *cannot* be practically used to predict someone's sexual behaviour, orientation, or identity…. knowing someone's genetic information allows us to guess their sexual behaviour just about as well as guessing with no genetic information at all."** (Ganna et al., 2019b, italics emphasis in original)

42. The largest-ever twin study (Polderman et al., 2015), like the largest-ever gene study above that looked at genetically verified relatives (Ganna et al., 2019a, 2019b), also found the genetic heritability for same-sex sexuality to be 32%[1].

43. This largest-ever meta-analysis of twin studies was published in 2015 "of virtually all twin studies published in the past 50 years [previous to 2015], on a wide range of traits and reporting on more than 14 million twin pairs across 39 different countries." (Polderman et al., 2015; Center for Neurogenomics and Cognitive Research, 2015, p. 7, see also abstract)

a. The rate of 32% heritability is the rate of *genetic variance*, that is, again, the rate at which genes are associated with the difference between people who as a group experience same-sex sexuality and those who as a group do not experience same-sex sexuality. It does not tell us the degree to which an individual's same-sex sexuality is attributable to genes. For example, an individual may not have all of the genes so far found to be associated with same-sex sexuality.

b. Some examples of specific twin registry studies similarly found a modest genetic contribution to same-sex behaviour. The twins in these studies may have been included in the largest-ever twin study described above. (Polderman et al., 2015)

iii. 31% overall in an Australian community twin registry of 9,884 twins. (Zietsch et al., 2012)

iv. 34% to 39% for males and 18% to 19% for females in a Swedish population-based registry of 3,826 twins. (Langstrom et al., 2010)

44. The 32% genetic heritability for same-sex sexuality can be put into perspective by comparing it to the heritability for other traits that have been researched by twin studies based on the premise that identical twins essentially share the same genes and based on sibling research based on the premise that siblings significantly share genes.

a. Polderman et al (2015) observed that all human traits studied had a genetic heritability. **The average heritability for *all* human traits studied, including *all physical and psychological traits* studied, was 49%.** (abstract and supplemental information[2])

[1] 32%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "ICF/ICD 10 Subchapter"; under "Acquired Absence of Organs…" choose "Psychological and behavioural…sexual development and orientation"; scroll down to "*h*2_all" = 0.32. "*h*2 all" = genetic contribution or heritability for all; "ss" = "same sex;" "m" = "male;" and "f" = "female." (Polderman, no date)

[2] 49%: Polderman, 2015, p. 1; go to end of article link to http://match.ctglab.nl/#/specific/plot1 ; "under All Traits" scroll all the way down to "*h2*_all" = 0.49. Polderman et al. (no date).

b. **The average genetic heritability for *all psychiatric traits* studied was 46% (Polderman et al., 2015, supplemental information [3]). Therefore, the heritability for same-sex sexuality (32%) is below average for all traits studied (49%) and below the average for traits (46%) that mental health professionals help people manage, decrease, or change every day.**

c. **Some twin studies have found that genetic heritability is 40% to 60% for smoking, being divorced, or feeling body dissatisfaction, traits that are widely considered changeable** (Diamond & Rosky, 2016; Vink, Willemsen, & Boomsma, 2005) through life experience or professional psychological or counselling intervention. As evidence, the American Psychological Association advocates professional counselling for smoking cessation (Novotney, 2022), and the British Psychological Society offered a response to the Health and Care Committee that recommended therapies and specialised psychological support for body dissatisfaction conditions (BPS, 2022). According to the American Association for Marriage and Family Therapy in 2020 (AAMFT, 2020), in the United States there were 48,000 marriage and family therapists, and all 50 states recognise marriage and family therapy. Marital therapy or counselling commonly supports couples who wish to avert divorce. The heritability for same-sex sexuality is lower than for these traits.

d. **The genetic heritability for more traits for which professional help is frequently given,** according to the largest-ever twin study, were obsessive-compulsive disorder 45%, eating disorders 40%, depressive episode 34%, and interpersonal interactions and relationships 32%--all traits that psychotherapists and counsellors help clients manage, decrease, or change regularly. For further comparison, the genetic contribution for religion and spirituality was 31%. (Polderman et al., 2015, these rates were published in online supplemental data at link on p. 7.)

e. **Genetic contribution estimates based on the largest-ever twin-survey-based studies in Polderman et al. (2015) were found to be "remarkably similar" to estimates based on physician-diagnosed psychiatric traits in a Swedish national registry study** of 4,408,646 full and maternal half siblings and genetic data on 333,748 individuals (125,533 individuals who had psychiatric disorders and 208,215 peers from the general population for comparison). In both large studies, a genetic contribution of 32% would be at the lower level in the range for psychiatric traits. **When the genetic contribution is less than 50%, environmental influences play a crucial role, and trauma may increase the likelihood of developing the trait.** (Pettersson et al., 2019, pp. 1169, 1170)

f. **Thus, the genetic contribution to same-sex attraction or behaviour is below average for all traits studied and for all psychiatric traits studied, not unusual or special. There is no *genetic* reason why same-sex sexuality should be**

[3] 46%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "Domain;" under "Activities" choose "Psychiatric;" scroll all the way down to "*h*2_all" = 0.46. (Polderman, no date)

considered unchangeable through psychotherapy or counselling conversations.

g. **Based on this largest-ever twin study, there is no genetic reason to assume that individuals experiencing a conflict between their sexual attraction feelings and their religious self would be more authentically their real selves if they sided with their same-sex sexuality than with their religious self. The genetic contribution to religion, 31%, is virtually the same as the genetic contribution to same-sex sexuality, 32%.** (Find 31% heritability for spirituality and religion in Polderman et al., 2015, shown on the article's link to supplemental information[4]; see also a research summary about the same time in Hvidtjorn et al., 2013). An additional meta-analysis of twin studies published between 1999 and 2021 (Kandler, 2021, abstract) found the genetic contribution to "externalized religiousness" defined as "quantity of religious practices and service attendance" was 39%, and the genetic contribution to "internalized religiousness" defined as "religious beliefs and the importance of religion in life" (p. 106) was 28%. (Figure 1)

45. **The combined findings of these mutually confirmatory, largest-ever, most statistically powerful, quantitative, peer-reviewed gene studies using different research methods—the genome-wide association study, the study of genetically confirmed close relatives** (Ganna et al., 2019a, 2019b), **and the meta-analysis twin study** (Polderman et al., 2015; Center for Neurogenomics and Cognitive Research, 2015[5]) **have established that genes make only a minor contribution to same sex sexuality. *Genes would never be the sole factor leading to same sex sexuality.***

46. ***Transgender identity*** **and transgender** ***role or expression*** **also are not genetically determined.** A review of gene studies indicated that, as is the case for other traits, any genetic heritability for transgender identity or role/expression likely comes from many genes that each make a small contribution and, taken together, fall into the average *range* (30% to 60%) for other personality traits. Hence, transgender identity is hypothesised to develop from an interaction of biological and environmental influences. (Polderman et al., 2018) Genetic associations with male-to-female transgender identity have been reported as potentially contributing to brain under-masculinisation and/or to brain feminisation but not to determining transgender identity. The data is weak and inconclusive. (Henningsson et al., 2005; Foreman et al., 2019; White, 2019, comment on Foreman et al., 2019)

47. **Further, gender** ***dysphoria*** **also is not genetically determined**. For the purpose of this report, gender dysphoria is the experience of distress some people feel if their gender

[4] 31%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "ICF/ICD 10 Subchapter;" under "Acquired Absence of Organs…" choose "Religion and Spirituality;" scroll down to "*h*2_all" = 0.31. (Polderman, no date.

[5] Find .32 here: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "ICF/ICD 10 Subchapter;" under "Acquired Absence of Organs…" choose "Psychological and behavioural…sexual development and orientation;" scroll down to "*h*2 all = 0.32." "*h*2 all" = genetic contribution or heritability for all; "ss" = "same sex;" "m" = "male;" and "f" = "female." (Polderman, no date)

identity is incongruent with their sex. Not everyone who experiences a gender identity that is discordant to their sex feels distress about it. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (American Psychiatric Association, 2022, DSM-5-TR; also 2013, DSM-5) defines gender dysphoria as a psychiatric condition that is not simply biologically determined, in line with the findings of the following research.

48. **A study of all twins in Sweden over 15 years of age in which one twin had gender dysphoria found that virtually always the other twin did not have gender dysphoria, nor did any siblings.** Swedish researchers (Karamanis, Karalexi, & White, 2022) said most people who experience gender discordance do not develop gender dysphoria, meaning distress about the mismatch between their discordant gender identity and their sex. People who experience gender dysphoria are a subgroup within people who experience gender incongruence. To investigate genetic influence on gender dysphoria, they conducted a robust Swedish national registries study that looked at all 67 twin pairs and 2,534 sibling pairs of individuals who were least age 10 years of age where at least one individual in the twin pair was diagnosed with gender dysphoria during the period of 2001 through 2016. They found no same sex twins (0%), virtually no non-twin siblings (0.16%), and a minority of opposite-sex twins (37%) were concordant for gender dysphoria. In short, individuals who had gender dysphoria virtually never had a sibling who was gender dysphoric unless that sibling was an opposite-sex twin, and usually not even then. These findings do not support that genes determine gender dysphoria.

    a. The researchers noted that concordance was greater between opposite-sex twins than opposite-sex siblings, and they suggested that prenatal influences contributed to the development of gender dysphoria. If so, they are not determinative, and more influences are needed.

    b. Could childhood gender socialisation, however, be an influence? Bearman and Bruckner (2002) suggest that gender socialisation may be different in opposite-sex twins compared to opposite-sex siblings. Some parents may raise opposite-sex twins more nearly alike, resulting in a boy who is less masculine gender socialised. These researchers raised only the question of whether gender socialisation could influence development of same sex sexuality, but could gender socialisation also influence the development of gender identity? Bearman and Bruckner found that, in the case of sexuality, boys who were opposite-sex twins were more likely to develop same-sex romantic attraction **unless they had an older brother** (concordance if no older brother = 18.7%, if older brothers = 8.8%, with and without older brothers = 16.8%; p. 1196, footnote 7, table 3) suggesting a path of masculine gender development had already been paved in the family if there was an older brother, and the boy had more help to be socialised in masculinity. The fraternal birth order effect for same-sex attraction in opposite-sex twins was in the direction of *decreasing* same-sex attraction. More research is needed to explore whether similar findings may also hold for opposite-sex twins where one experiences gender *dysphoria* and there is an older same-sex sibling, perhaps especially in the case

of boys. Might same-sex attraction, incongruent gender identity, and the frequency with which they occur together be influenced by social experiences?

c. Gender dysphoria may still occur in opposite-sex twin boys who have older brothers, and other influences may exist, for example if there are adverse experiences associated with the older brother.

49. Hypothesised prenatal environment influences on *brain structures*. There is a view that "gay men, lesbians, and transgender people of both sexes have brains that are 'wired' differently from most people, and that accepting this is an important component of combating anti-gay prejudice." (Jordan-Young 2010, p. 5) This view is the neurohormonal or brain organisation theory. It hypothesises that prenatal hormones may influence the brain or brain structures of a female foetus to be more masculinised or the brain or brain structures of a male foetus to be less masculinised, setting in place *permanent* patterns of desire, personality, temperament, and cognition. Further, it is hypothesised, hormones later in life could activate these early predispositions (Jordan-Young, 2012, p. xi) There are several problems with this theory.

a. **The brain is not organised once and for all before birth. It changes lifelong through life experience.** A comprehensive research review of the brain organisation theory analysed over 300 studies from 1967 through mid-2010 and interviewed 25 of the most influential scientists at the time and concluded, "the evidence simply does not support the theory." (Jordan-Young, 2010, pp. xi-xii) A major problem with the theory is that the human brain undergoes major expansion after birth and continues changing into adulthood, if not lifelong, in constant interaction with life experiences. (p. 106) Therefore, neither brain structures nor sexual or gender predispositions can be permanently set before birth. Rather, the development of all of these is influenced by life experiences, potentially throughout the life span. (Jordan-Young, 2010, 2012)

b. **Research into whether prenatal hormones influence development of gender dysphoria has significantly relied on studying people who have disorders of sexual development (DSDs), some of which are popularly referred to as "intersex" conditions. (Saraswat et al., 2015) Most people who have transgender identity, however, do not have disorders of sexual development.** (Carmichael et al., 2000; Saraswat, 2015) As evidence of this, for example, a study at the Tavistock clinic of a selected cohort of gender dysphoric children ages 12 to 15 found, "All had normal karyotype and endocrine function in 44 GD [gender dysphoric] youth." (Carmichael, et al., 2000) **Also, as we will immediately discuss, women who have the disorder of sexual development known as congenital adrenal hyperplasia (CAH), that is commonly claimed to show prenatal hormones may cause gender dysphoria, usually do not develop either gender dysphoria or same-sex sexuality.** (Gastaud et al., 2007; Stout et al., 2010; Jordan-Young, 2012; Zucker et al., 2016)

c. **A model for testing whether prenatal hormones create same-sex attraction brains or gender-incongruent brains has come from studies of girls diagnosed with congenital adrenal hyperplasia (CAH). Women who have CAH received far higher doses of prenatal androgens than non-CAH lesbian or bisexual women would be expected on average to receive, in fact doses at the higher end of the normal range in males or slightly higher, so high that they typically are born with masculinised genitals.** It has been hypothesised that there are phases of prenatal development when hormones permanently organise the brain for sexual orientation or gender identity. CAH women receive these very high doses of androgen throughout their prenatal development, covering all such potential phases. If prenatal androgen were a primary contributor to same-sex sexuality or transgender identity, one would surely expect that girls with CAH would uniformly develop strong and stable sexual and romantic attraction for women (Jordan-Young 2010, 2012; Stout et al., 2010; Diamond & Rosky 2016, pp. 5-6) and transgender identity.

    i. Research studies have found, however, that most women with CAH, even many with the most severe form of CAH, had exclusive or almost exclusive heterosexual fantasies and heterosexual behaviour if they were sexually active, while some showed an elevation in same-sex fantasies but less elevation in same-sex sexual behaviour. (Gastaud et al., 2007; Hines 2011, p. 17; Meyer-Bahlburg et al., 2008; Stout et al., 2010; Daae et al., 2020).

    ii. Though CAH girls showed a higher rate of male gender identity or role, the vast majority of these biological females developed an unremarkable female gender identity. (Gastaud et al., 2007; Stout et al., 2010; Jordan-Young, 2012; Zucker et al., 2016) A global consensus statement of endocrine societies around the world said 95% of CAH women develop a female gender identity. (Lee, Nordenstrom, et al., 2016) "An Endocrine Society Scientific Statement" on "Sex as a Biological Variable" in research said most women with *severe* CAH who have "*severely* virilised external genitalia" have a female gender identity and are heterosexual, "but about 5% to 10% of such individuals have gender dysphoria, an atypical gender identity, *or* atypical sexual orientation and gender behavior." (Bhargave et al., 2021, p. 227, italics added)

    iii. **Researchers who simply attributed these relative increases in same-sex sexuality or gender identity to hormone-driven masculinised brain organisation systematically ignored how masculine features might contribute to CAH girls' psychosexual development.** Researchers ignored, for example, the social priming effect on physicians' and parents' expectations of the girls' gender or sexuality development stemming from the girls' physical appearance or presentation which included: atypical genitalia, male-pattern (frontal)

baldness, greater body hair, a deep voice, obesity while also being somewhat shorter, and severe cystic acne, features that do not fit a common stereotypical view of femininity. Given such experiences, the girls unsurprisingly had high rates of negative body image. Physical appearance may have reduced romantic approaches from men, and some girls may have suffered social isolation from peers (Meyer-Bahlburg et al., 2008; Stout et al., 2010; Jordan-Young, 2010, 2012). Additional impactful life experiences stemming from the prenatal hormone disorder were that most endured genital surgeries even in infancy and treatments such as vaginal dilation. Women with CAH described the regular medical inspection of their genitals throughout their childhood as "rape," "violation," and "intrusive and dehumanizing." Their experiences have been likened to childhood sexual abuse. (Jordan-Young, 2012, 2010) Further, they suffered from health problems in 8 domains, depression and anxiety that may have come from imbalance of steroid hormones, conception difficulties, and severe impairment in all aspects of sexual function and sexual pleasure. Given that most CAH women experience pain and some may experience bleeding in vaginal penetration (Gastaud et al., 2007, Hines, 2011, p. 8), it may not be surprising that they fantasised about same-sex relationships that do not presuppose vaginal penetration while they actually engaged in limited sexual behaviour with either sex. (Meyer-Bahlburg et al., 2008, abstract and pp. 87, 94; Jordan-Young, 2010, 2012; Zucker et al., 2016) One notable though older study found that whether or not there was heterosexual activity corresponded more closely with whether the vaginal opening was adequate than with the degree of prenatal androgen. (Mulaikal et al., 1987)

iv. **Postnatal influences are significant. Many scientists who have researched neurohormonal brain organisation theories have simply assumed prenatal hormones had a permanent causal effect, rather than correlation, and assumed a simple direct effect, without considering mediating or moderating effects including social responses of others** (Stout et al., 2010; Jordan-Young, 2010, 2012). Jordan-Young concluded from her review that neurohormonal brain organisation theory became a framework lens through which researchers interpreted findings on CAH girls while they ignored significant other influences on the girls' development of sexual fantasies or behaviour or gender identity. (Jordan-Young 2010, 2012)

v. **Prenatal hormone theories often do not sufficiently take into account that the brain largely develops *after* birth while it *continuously interacts* with life experiences**, and it *continues to change* through life experience *well into adulthood and possibly throughout life*. **Life experiences** shape childhood and adult development in directions that **may *add to, diminish, or entirely***

***mitigate* some possible prenatal influences** (Jordan-Young, 2012, e.g. pp. 286-288; 2010; Lee et al., 2016).

50. **The American Psychiatric Association's official diagnostic manual says the view that gender dysphoria is an intersex condition of the brain (in contrast to an intersex condition of the genitals) has not been substantiated.** It says, "Overall, current evidence is insufficient to label gender dysphoria without a DSD [disorder of sexual development] as a form of intersexuality limited to the central nervous system." (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision—DSM-5-TR,* 2022, p. 517) This is the diagnostic manual most used by gender services in European countries that participated in the gender services survey conducted at York University for the Cass report for NHS-England (Hall et al., 2024, Gender Services, p. 5)

51. **The final Cass report commissioned by NHS England accepts:** (Cass, April 2024, p. 115)

> **8.11** However, there is still no clear evidence that altered hormonal levels prenatally or during puberty are responsible for the development of gender incongruence, apart from those with DSD, and this is a difficult area in which to test hypotheses.

52. **The maternal immune response hypothesis and the brain. This hypothesis is another brain organisation theory. It was developed in an attempt to explain a research finding that males who have same-sex preference, on average, have more older brothers than do males who have opposite-sex preference. The phenomenon is commonly referred to as the *fraternal birth order effect (FBO effect or FBOE)*.** The American Psychiatric Association's diagnostic manual (DSM-5-TR) (American Psychiatric Association, 2022) also accepts that males "with gender dysphoria without a DSD [disorder of sexual development] (in both childhood and adolescence) more commonly have older brothers". (p. 517) Social and biological hypotheses have been offered to account for an association between having older brothers and same-sex sexuality and for a potential causal link between these.

    a. **The FBO effect has been estimated to contribute indirectly or directly to 15.1% to 28.5% of men who experience same-sex attraction.** Expressed another way, if no boys had older brothers, the percent of boys who developed same-sex attraction would be 15.1% or 28.5% less. (Cantor et al., 2002; Blanchard & Bogaert, 2004)

    b. **The fraternal birth order (FBO) effect size is modest.** With each older brother, the likelihood that a boy will develop same-sex attraction increases 33%. (Blanchard & Bogaert, 1996; or 38% in Blanchard et al., 2020) Researchers explain this means that, if one estimates that, among all men, the proportion in the general population who develop homosexual or bisexual attraction is 2%, the likelihood a boy will develop homosexual or bisexual attraction if he has 1, 2, 3, or 4 older brothers is 2.6, 3.5, 4.6, and 6.0% respectively, still a small

likelihood. **In other words, if a boy has 4 older brothers, the overwhelming likelihood (94% likelihood) is that his sexual attraction will be heterosexual or mostly heterosexual.** (Blanchard & Bogaert, 2004) Per a nationally representative study in the U.S., most boys who had any older brothers had one. (Francis, 2008)

c. **The maternal immune hypothesis (MIH) proposes a biological explanation for the FBO effect.** It posits that some mothers develop antibodies against a protein that is linked to the male (Y) sex chromosome in a male foetus, and that this effect increases with each of a woman's pregnancies with a male foetus. This process is hypothesised to alter the typical sexual differentiation of the male foetus's brain along a less masculine/more feminine path but allows the masculine development of the genitals to proceed normally. On this theory, a less masculinised brain is thought to influence sexual preference directly or indirectly. (Bogaert et al., 2018; Cantor et al., 2002)

d. **The maternal immune hypothesis cannot explain same-sex sexuality in firstborn sons or boys who have no older brothers** (unless their mother previously had miscarriages of boys).

e. **Evidence contrary to the FBO effect and the maternal immune hypothesis is that identical twin boys share the same number of older brothers, but if one has same-sex sexuality, the other usually does not.** (Bailey et al., 2016, p. 76) Blanchard (2018b, p. 51) has commented on the difficulty of studying the maternal immune hypothesis in identical twins, hence he has not done it, and he has offered some speculations as to whether one identical twin could be affected by intrauterine environment but not the other.

f. **Another hypothesised explanation for the FBO effect is that older brothers may exert nonbiological, social-psychological influences leading to nonheterosexuality**.

    i. **Principal researchers of the FBO effect have noted that some authors "have speculated that the presence of older brothers increases the likelihood of sex play between boys, and that such activity may condition boys to homosexuality**". They continue, "If one adds to this the assumption that a younger brother has a greater chance of being so conditioned, then the observable result would be a tendency for homosexual males to be born late among their brothers". (Blanchard & Skorska, 2022, p. 3340; see also Cantor et al., 2002) Observations by Australian researchers suggest obtaining data on the sexuality of older brothers to test the FBO effect, since the theory predicts that successive brothers would have increased likelihood of same-sex sexuality. (Vilsmeier et al., 2023, p. 48) The sexuality of older brothers might have some bearing on potential for sexual molestation of younger brothers.

ii. **Younger brothers may be exposed to greater risk of sexual abuse beyond the scope of their older brothers. It is likely that younger brothers who are around older brothers may also be around more older boys and men who are around older boys.** As a result, younger brothers may be subject to increased risk of same-sex sexual experiences or sexual molestation by older unrelated males or older brothers. Increasing numbers of older brothers may further increase risk.

iii. **There is some evidence that first sexual experiences with a male may shift sexuality toward males.** (Beard et al., 2013) **Large, prospective, longitudinal, controlled, cohort studies using different methods and in different countries have found evidence that sexual abuse may be one potentially causal influence for same-sex sexuality.** (Wilson & Widom, 2010, accepted by Mustanski, Kuper, & Greene, 2014 in *APA Handbook of Sexuality and Psychology, vol. 1*, pp. 609-610; Zietsch et al., 2012) While these studies do not specify the sex of the perpetrator, it is known that most perpetrators of sexual abuse are male. (Holmes & Slap, 1998) A high rate of childhood sexual abuse has been reported among clients who sought change-allowing therapy or pastoral counselling. (Nicolosi, Byrd, & Potts, 2000)

iv. **Girls may also experience greater risk of sexual abuse from older brothers or their male associates. It has been hypothesised that sexual abuse by males may also increase same-sex sexuality in females. The sexual abuse explanation for the FBO effect would predict an FBO effect for girls, not only boys. An FBO effect for girls would support the sexual abuse hypothesis but would contradict the maternal immune hypothesis as originally conceived. As research methods have appeared to improve, the fraternal birth order effect has been increasingly confirmed for girls.** (Ablaza, Kabátek & Perales, 2022)

g. **At the same time, there is also evidence that boys who had older biological brothers, rather than older stepbrothers or older adopted brothers, had a modestly higher likelihood of developing same-sex sexuality, whether or not the biological brothers were raised together or apart. This would support a biological explanation. (Bogaert, 2006) The research basis was a study on 4 convenience samples of participants. It has been suggested a problem with these findings may be small sample size. (Puts, Jordan, & Breedlove, 2006)**

h. **So far, there is no direct evidence supporting the maternal immune response explanation for the older brother effect.** (Bailey, 2018). A recent experiment, likely the first one, that found support for the hypothesis used small numbers of participants and vanishingly small control groups. (Bogaert et al., 2017). Although no generalisations can be drawn from this study, it may generate a larger and more definitive one.

i. **Researchers have criticised participant selection and methodological reasoning** used in studies on which the FBO effect and maternal immune hypothesis have relied.

j. **Some critics have said researchers included studies that had highly nonrepresentative samples of people who have same sex sexuality, and the sample selection may have created the FBO effect.** These samples included "sex offenders, transsexuals, and patient samples (pedophilia, gender dysphoria, sexually transmitted diseases, psychoanalysis)" without noting or addressing this issue yet excluded all of the available representative samples, all but one of which did not find the FBO effect, "because of more minor problems". **It was suggested "that sampling peculiarities are creating the fraternal birth order effect".** (Zietsch, 2018 critiqued Blanchard, 2018a; Vilsmeier et al., 2023 concurred with Zietsch, 2018) **Blanchard has conceded that "The evidence from the feminine/transgender samples is unclear, because there may be one or more things perturbing the expected distribution of effect estimates."** (Blanchard, 2018b, p. 50)

    i. **Some critics also have said that, throughout the research studies finding the FBO effect, researchers relied on incorrect statistical reasoning,** for example relied on the idea that it was necessary to correct for family size (not only number of *older* siblings) (Zietsch, 2018; Vilsmeier et al., 2023) and on an idea about how it could be done (Vilsmeier et al., 2023)

    ii. **A comprehensive analysis by Austrian researchers concluded males who experienced same-sex sexuality did have more older brothers, but the effect was small, and women who had same-sex sexuality also had more older brothers, contrary to early research findings on which the maternal immune hypothesis was originally built.** (Vilsmeier et al., 2023, p. 45) The Austrian researchers conducted a new analysis inclusive of multiple samples, the eighth such study, and the first "encompassing all extant male and female samples" that were obtainable, including the entire set of 81 samples (64 male and 17 female samples, 2,778,998 participants), "the most thorough and methodologically sound investigation" of the FBO effect and the maternal immune hypothesis "to date", the researchers said. (Vilsmeier et al., 2023, abstract, pp. 5, 22).

    iii. **This study was criticized, however, for including a very large data set that was said to contain systematic error and be invalid.** Critics (Blanchard & Skorska, 2022) said the Austrian researchers (Vilsmeier et al., 2023) relied on a very large sample of Danes (Frisch & Hviid, 2006) in which it has been said that the ratio of males to females (older siblings of heterosexual males and females) was orders of magnitude different from the typical population ratio of 106 males to 100

females, hence there is something seriously wrong with the data set. (Blanchard & Skorska, 2022, critiqued a preprint version of Vilsmeier et al., 2023, now in print.)

iv. **Advocates of the maternal immune hypothesis acknowledge that older brothers may be a very fallible means of measuring it. Not all sons may expose their mother to immunization, while some miscarriages, possibly undetected, may do so. Researchers in support of the maternal immune hypothesis have said, "On this view, the exact magnitude of the correlation between probands' number of older brothers and their sexual orientation is not nearly as important as the reliability and direction of the effect.** The ultimate significance of the FBOE may lie, not in the phenomenon itself, but rather in its potential role as a bridge toward laboratory research." (Blanchard & Skorska, 2022, p. 3340)

k. **In the largest study to date by far (Ablaza, Kabátek & Perales, 2022), evidence of the FBO effect was found to be robust for male homosexuality, consistent with the maternal immune hypothesis, but also to be robust for female homosexuality, if anything larger for women (p. 25), contrary to the FBO effect and the maternal immune hypothesis as originally conceived. Researchers said this finding "suggests that this hypothesis may need to be reconsidered or refined to incorporate women." (p. 23) The only sibling characteristic greater for entering a homosexual union for men than women was individuals' own late birth order.** (p. 25) For example, "0.73% of men who are the youngest of five siblings entered a same sex union, compared to just 0.35% of men who are the eldest of five siblings" (p. 17), still a very small percent.

i. **Using high quality linked registry data for the national population of the Netherlands** (9,073,496 total individuals), the study compared the near universe of individuals who entered a same-sex marriage or registered partnership over the past 70 years up to December 2019 (26,542 men and 33,534 women, total 60,076) to those who did not (4,607,785 men and 4,405,635 women). (Abstract and p. 9) The number of individuals in a same sex union in this study is 18 times the size of another large study of individuals in same-sex unions (3,463) in Denmark (Frisch & Hviid, 2006) and 3 times larger than all previously available data combined (Vilsmeier et al., 2023, p. 7).

ii. The researchers of the Netherlands' study expected their subsample of non-heterosexuals, namely individuals who were in a same-sex union, to adequately approximate nonheterosexuals in associations of interest for the purpose of this study. (p. 10)

iii. "With high precision", the researchers reported, their unique methods studied separately the influence of birth order, sibship size, and

siblings' sex, accounting for all sibship configurations and allowing for the inclusion of sisters.

l. **Researchers have conceded some problems with evidence for the FBO effect and maternal immune hypothesis as originally conceived. They have made recommendations for further research.**

i. **Advocates of the FBO effect (Blanchard and Skorska, 2022), have accepted that the fraternal birth order effect and maternal immune hypothesis as originally conceived are not supported by the best research to date and have now extended the maternal immune hypothesis to include women** in response to the study from the Netherlands (Ablaza, Kabátek & Perales, 2022) and in reaction to a preprint version of the now published Austrian critique (Vilsmeier et al., 2023). (Blanchard & Skorka, 2023; Vilsmeier et al., 2023)

ii. **Acknowledging possible problems in some current data sets and limitations in current knowledge of the fraternal birth order effect and maternal immune hypothesis, leading researchers in this area recommend more research on fresh data sets.** They say, "It is unclear how much more there is to be gleaned from the existing data sets, most of which have now been analyzed, meta-analyzed, and meta-analyzed again. Whatever sampling error is present in these data is going to remain there, and such error might simply distort one analysis after another. The ideal approach to moving this research forward would be the collection of fresh samples". (Blanchard & Skorska, 2022, P. 3339)

iii. **Researchers have suggested conducting laboratory research** that would include testing the extension of the maternal immune hypothesis to women. (Blanchard & Skorska, 2022)

iv. **Some researchers on the FBO effect have noted other potential factors that should be studied, preferably on large data sets.** They have urged "Large-scale studies**,** incorporating a host of potentially relevant explanatory variables". (Vilsmeier et al., 2023, p. 48) **There are a number of examples of existing large-scale data sets used in studies in my report.**

v. **Being the youngest boy in a family should be studied, as it was a larger effect for developing same-sex sexuality than the FBO effect for boys and the only effect larger for boys than for girls in The Netherlands study.** The largest-by-far and most methodologically rigorous study to date, conducted in the Netherlands, found late birth order for boys in itself was a larger sibling effect for developing same-sex sexuality than the FBO effect for boys and girls. (Ablaza, Kabátek & Perales, 2022)

vi. **Some FBO effect researchers have said, "There is ample evidence that a host of other factors" such as absence or loss of a parent, especially the parent of the same sex as the child, are associated with same-sex sexuality, and these should be studied.** (Vilsmeier et al., 2023, p. 48)

vii. **Other social factors in the family that should be explored may serve to prevent, mitigate, or intensify risk of adverse social events and potential impacts from older brothers or their male associates,** such as protective and positive relationships between boys and girls and their older brothers, father, or mother or, by contrast, a poor relationship with father, mother, or older brothers. There is evidence that boys who live with their mother only, that is, whose father is absent, are at greater risk of sexual abuse (Holmes & Slap, 1998). These boys would not have a father's protection to prevent abuse, attachment with father to help build resilience to adverse experiences, or father support to help repair adverse effects. Quality of parent relationships with older brothers may also be a factor as well as parent relationships with younger sons and daughters.

viii. **Other aspects of relationships with older brothers and their male peers, such as bullying or rejection should be explored for potential impact on sexuality development.** Boys who appear less stereotypically masculine may experience more ostracism, bullying, or rejection from older brothers, other boys, men, and their father. One hypothesis is that these experiences may leave them with painful yearning for male affirmation and belonging, and this yearning may become sexualised in puberty, leading to seeking affirmation sexually from men, as some clients of change-allowing therapy have expressed. (Nicolosi, 2009, pp. 42-43, 83, 99; Byrd, Nicolosi, & Potts, 2008)

m. **Even if further research establishes that the maternal immune hypothesis contributes to gender atypical expression in a small subset of boys or girls, the effect is modest, and atypical gender behaviour does not equal same-sex attraction. It may be expected that additional influences would be needed to develop same-sex sexuality in impacted children.**

n. **Blanchard acknowledged the limited effect of the FBO to same-sex sexuality, saying,** (2018b, p. 54)

> The MIH was never intended to explain the sexual orientation of homosexual men. It was intended to explain the sexual orientation of a subset of homosexual men, namely those who have a statistical excess of older brothers. The available evidence indicates that that subset is a minority. Thus, the notion that there must be causes of

homosexuality besides maternal anti-male antibodies is not merely consistent with the MIH; it is more or less implied by it.

53. Epigenetic theories and the brain. Epigenetic influences have been hypothesised to explain ways that a boy might be born less masculinised or a girl more masculinised. (Ngun & Vilain, 2014; Rice, Friberg, & Gavrilets, 2012; Gavrilets, Freibeg, & Rice, 2018) These gender-atypical traits, again, do not equal same-sex attraction feelings or behaviour or incongruent gender identity or expression. Gender atypical tendencies or characteristics may, however, lead to social experiences that may in turn be influences toward such outcomes for some. Epigenetics refers to the chemical modification of genetic material leading to changes in gene expression. Epigenetics may silence, modify, or intensify the strength of a gene's expression. Some epigenetics effects come about through environmental exposure or life experiences. Usually, these modifications on genes are erased when genes are passed down to the next generation, but sometimes genes are inherited un-erased, that is, in the same state as they were in for the parent. Thus, some epigenetic effects are inherited. Epigenetic theories of development of same-sex sexuality or incongruent gender identity are versions of brain organisation theory. Researchers of one epigenetics theory have said since 2013 that their theory "can be readily tested experimentally, using current technology on human stem cells" (Rice, Friberg, & Gavrilets, 2013), yet there does not appear to be compelling affirmation of the theory published to date.

54. Theories of sex of the brain. A person cannot simply be born with the brain of the opposite sex. Some brain features are strictly dichotomized as male and female corresponding to genetic sex. Some other features are on a spectrum from more masculine to more feminine and are not dichotomized as male or female. There is no scientific evidence to support the assertion that a person can have the brain of the opposite sex. Further, a person cannot be born with a brain that is fixed from birth to death. Our brains are plastic and develop or change lifelong in interaction with experiences in the environment.

a. **First, some brain differences are fixed as male or female. Every cell of a person's body that has a nucleus, including in the brain, has the chromosomes of that person's own sex. At the cellular level, a male has a male sexed brain, and a female has a female sexed brain. At the level of brain features, there are brain features that are distinctly different for males and females and that are fixed differences. (Ryali et al., 2024) There is no scientific evidence that a person can have the brain of the opposite sex with regard to these features.**

b. **Some brain features are, however, not strictly dichotomized to male brains or female brains. They are on a spectrum from more male-typical to more female-typical with large overlap between the sexes. These features may be influenced by life experiences and behaviours.**

    i. An "Endocrine Society Statement" reported that studies have independently replicated, using different laboratories, datasets, and

techniques, that there are "largely overlapping" differences on average between men and woman in volume of grey matter in various regions of the brain. The statement noted, "It is important to point out that observed group-level differences in brain structure, function, or connectivity in men and women may reflect the influence of several extraneous factors." (Bhargave et al., 2021, p. 233) These may include professional work, years of performing certain tasks, training, social environments, and behaviours. In both sexes, the brain retains its plasticity and potential for experiences and societal influences to shape brain development. It is usually impossible to disentangle biological sex differences from differences due to other influences such as these. (Bhargave et al., 2021, pp. 233, 236)

ii. Researchers analysed MRIs of more than 1,400 human brains from four data sets. They found extensive overlap between "females and males for all grey matter, white matter, and connections assessed." With respect to these features, they concluded that a brain is not simply a male brain or a female brain. They reported,

> Our findings are robust across sample, age, type of MRI, and method of analysis. These findings are corroborated by a similar analysis of personality traits, attitudes, interests, and behaviours of more than 5,500 individuals, which reveals that internal consistency is extremely rare. Our study demonstrates that, although there are sex/gender differences in the brain, human brains do not belong to one of two distinct categories: male brain/female brain. (Joel et al., 2015, abstract)

55. **Gender traits develop and may modify lifelong through interaction of biological influences and life experiences. What we think about and do modifies our brain.** This is according to a comprehensive research review, *Delusions of Gender: How Our Minds, Society, and Neurosexism Create Difference*. The author, Fine (2010), challenges neurosexism, defined as a belief that gender differences are simply biologically hard-wired in the brain. Fine asks the pointed question,

> But really when you think about it, where else but in the brain would we see the effects of socialisation or experience? As Mark Liberman puts it, "how else would socially constructed cognitive differences manifest themselves? In flows of pure spiritual energy, with no effect on neuronal activity, cerebral blood flow, and functional brain imaging techniques?" (Fine, 2010, pp. 170-171)

Fine explains,

> We tend to think of the chain of command as passing from genes to hormones, to brain, to environment…. Yet most developmental scientists will tell you that one-way arrows of causality are just *so* last

> century. The circuits of the brain are quite literally a product of your physical, social, and cultural environment, as well as your behaviour and thoughts. What we experience and do creates neural activity that can alter the brain, either directly or through changes in gene expressions. This neuroplasticity means that, as Kaiser puts it, the social phenomenon of gender "comes into the brain" and "becomes part of our cerebral biology." (Fine, 2010, pp. 235-236)

56. **There is no consistent evidence that the brains of gender *incongruent* people are different from the brains of gender *congruent* people according to a global consensus statement of endocrine societies and additional professional organisations—at least 8 professional organisations around the world:** the American Psychiatric Association (DSM-5-TR, 2022, p. 517), the American Psychological Association (Bockting, 2014, in *APA Handbook*, v. 1, chapter 24, p. 743), and international endocrine societies that published a global consensus consortium update, namely the European Society for Paediatric Endocrinology (ESPE), the Paediatric Endocrine Society (U.S.A.), the Asian Pacific Paediatric Endocrine Society, the Japanese Society of Paediatric Endocrinology, the Sociedad Latino-Americana de Endocrinologia Paediatrica, and the Chinese Society of Paediatric Endocrinology and Metabolism. (Lee, Nordenstrom et al., 2016)

    a. **The global consensus consortium update says there is *no biomarker* for gender identity. That is, there is no biological thing that has been found that is gender identity that another person can find by looking at a person's brain or conducting a biological test.** The update states (Lee, Nordenstrom et al., 2016),

> A biomarker of gender identity is not (yet) available. Although a number of studies have published differences in central nervous system (CNS) structures between transgender and cisgender adults, these studies use a variety of brain-imaging (or cadaver-sectioning) techniques; the findings are heterogeneous and lack replication; and where there are structural differences, they usually overlap to a considerable degree between transgender and cisgender samples, so that they are not yet useful for individual gender categorisation. Moreover, our current knowledge of the structures and functions of the CNS [central nervous system, that is, the brain] underlying gender identity is insufficient to read MRIs for the presence of a specific gender identity. Even if at some point in the future such an interpretation of MRI findings should become possible for individuals at later stages of cognitive development, it is questionable that the brain of a newborn is developed enough for the prediction of gender identity years later, given the gradual development of critical sex-dimorphic aspects of the CNS [72]." (p. 168)

b. **The final Cass report accepts:** (Cass, April 2024, p. 116, bold added)

> 8.20 As imaging technology continues to advance, brain studies will remain a rich source of further information. **However, to date, research in this area has not reliably identified brain changes directly linked to gender incongruence. Even if they could, this might not provide information on [direction of] causality.**

c. **This is because thinking about and expressing same-sex sexuality and gender discordant identity or expression changes the brain.** To review, what we think about and do changes our brain. If gender differences in brains were proven to be linked to same-sex sexuality or gender discordant thoughts, feelings, or expressions, it could mean these thoughts, feelings, and expressions caused the differences in the brain, not necessarily that gender atypical brains or brain structures caused the same sex sexuality or gender discordance.

57. Gender nonconforming behaviour is not same-sex sexuality or gender discordant identity. An abundance of studies on many prenatal brain organisation theories may tell us more about gender nonconforming behaviour. They do not by themselves explain same-sex sexuality or discordant gender identity, because gender nonconforming behaviour and these traits often do not go together. There have to be more influences either with or without gender nonconformity for same-sex sexuality or gender discordant identity to develop.

a. **There are many children who have gender-atypical traits or role expression yet do not develop incongruent gender identity.** The American Psychological Association, the American Psychiatric Association, the International Classification of Diseases (ICD), the Global Consensus Consortium of endocrine societies, the Endocrine Society (U.S.) and research findings on girls who have the CAH disorder of sexual development all concur on this. Even if a boy engages in less masculine behaviour or a girl engages in more masculine behaviour, and even if we considered these gender behaviours to be caused by prenatally influenced brains or brain structures, these traits still do not equal incongruent gender identity, and there would have to be more influences to get to an incongruent gender identity.

i. **The American Psychological Association's *APA Handbook of Sexuality and Psychology* says most children who have gender nonconforming behaviour do not have discordant gender identity.**

> According to their parents, 4.8% of boys and 10.6% of girls are gender role nonconforming, whereas 1% of boys and 3.5% of girls expressed the wish to be of the other sex, the latter being a possible indication of a cross-gender identity and associated gender dysphoria (i.e., discomfort with the sex or gender role assigned at birth…). Gender identity and gender expression or role often are confounded…. Only in a minority of children is

gender role nonconformity accompanied by early cross-gender identification. (Bockting, 2014, in *APA Handbook*, vol. 1, chapter 24, pp. 743-744)

ii. **The American Psychiatric Association's official diagnostic manual** says prenatal hormones are related more to gendered behaviour that gender identity. Gender nonconforming behaviour should not be considered an indicator of current or future gender dysphoria.

> However, the prenatal androgen milieu is more closely related to gendered behaviour than to gender identity. Many individuals with DSDs [disorders of sexual development, some of which are popularly called intersex conditions] and markedly gender-variant behaviour do not develop gender dysphoria. Thus, gender nonconforming behaviour by itself should not be interpreted as an indicator of current or future gender dysphoria. (*DSM-5-TR*, 2022, p. 516)

i. **The International Classification of Diseases (ICD) published by the World Health Organization** also says there is a distance between gender variant behaviour and preferences versus qualification for a gender incongruence diagnosis. "Gender variant behaviour and preferences alone are not a basis of assigning the diagnosis." (ICD-11: HA60 Gender incongruence of adolescence or adulthood, ICD-11: HA61 Gender incongruence of childhood, in WHO, 2022; conveniently accessible in Cass, April 2022, pp. 96-97)

d. **A Global Consensus statement of several endocrine societies around the world and the Endocrine Society (U.S.)** agree that girls who have the CAH disorder of sexual development due to prenatal hormones display gender atypical traits and even gender atypical genitals, but the vast majority develop heterosexual sexuality and gender identify with their female sex. (Lee, Nordenstrom et al., 2016; Bhargave et al., 2021)

e. **The American Psychological Association's *APA Handbook of Sexuality and Psychology* also says many transgender *adults* do not report they experienced gender nonconforming behaviour as children.** "Moreover, many adult transgender or transsexual individuals do not report a history of childhood gender role nonconformity." (Bockting, 2014, in *APA Handbook*, vol. 1, chapter 24, p. 744)

f. **Likewise, not all adults who experience same-sex sexuality experienced gender atypical traits as children or adolescents.**

i. **A qualitative study that contrasted the traits of gender nonconformity and same-sex sexuality in women found that "rejecting femininity" in childhood was far more predictive of a**

"lesbian/bisexual" status in adulthood than "choosing masculinity". The vast majority of women who recalled "choosing masculinity" in childhood without "rejecting femininity" were classified as "heterosexual" as adults. "Lesbian/bisexual" women reported far more rejection of femininity in childhood, whether they were "butch" or "femme". "Lesbian/bisexual butch" women reported that far higher rejection of femininity continued in adolescence. (Carr, 2005, Table IV)

ii. **While a larger portion of individuals who experience same-sex sexuality also experience gender noncomformity, a large proportion of gender nonconforming individuals are exclusively heterosexual.**

1. **In what appears to be the first rigorous, large, nationally representative, prospective, longitudinal study of both gender nonconforming behaviour and same-sex sexuality identity, the researchers reported their study supported previous research findings that "those who identify as homosexual or bisexual in adolescence or adulthood were more likely to have exhibited gender nonconforming behaviors during childhood". Specifically, the researchers in this first representative study found that "a greater proportion of sexual minority respondents reported gender-atypical behaviors." They also found, "However, these results do not suggest that gender-typed behavior predicts sexual orientation." In fact, "a large proportion of those who were gender nonconforming were also a part of the 100% heterosexual group". They reported, "For all groups, scores spanned the entire distribution, suggesting that self-reports of gender conforming and nonconforming behaviors were common among all youth, regardless of sexual orientation." They concluded, "Therefore, our results show that gender-typed behaviors vary among all sexual orientation groups". As a result, they explained, "thus sexual orientation should not be inferred from behavior."** (Kahn & Halpern, 2019, pp. 24-25. See Fish and Russell, 2018, on the "Add Health" data set that Kahn and Halpern used.)

2. Researchers who study early gender nonconforming behaviour in individuals who developed same-sex sexuality should consider studying these same gender nonconforming behaviours in children who became 100% heterosexual.

3. **An early systematic research review and meta-analysis of retrospective studies (retrospective studies rely on adult memories of childhood) found that most of the differences in childhood sex-typed behaviour occurred within sexual orientation groups rather than between them. Sexual**

orientation was associated with 37% of the differences among men and 21% of the differences among women, considered a large association. The findings supported that there were true differences in sex-typed behaviour among heterosexual participants and among homosexual participants. (Bailey & Zucker, 1995, p. 51)

g. **Gender atypical traits may develop *after* same-sex sexuality.** Some atypical gender expression traits, being relatively plastic, "may actually signal [be used to socially communicate] sexual interests and dispositions, rather than accompany or influence their development." (Valentova, et al., 2023)

58. **Life experiences influence sexuality and gender identity development far more than hypothesised prenatal biological influences. Identical twins share (imperfectly) all hypothesised biological influences on same sex sexuality and incongruent gender identity, but if one twin develops one of these traits, the other usually does not.** Identical twins share genes, epigenetic elements, prenatal hormones, and number of older brothers. Identical twins are the same sex in virtually 100% of twin pairs (exceptions are very, very extremely rare). Sex is biologically determined by genes and prenatal hormones and can never change. But if one identical twin develops same-sex sexuality, the other twin does also in only 14% of twin pairs. (Bailey et al., 2016, pairwise concordance for monozygotic twins of 14% (.14) calculated from proband concordance of 24% (.24) on p. 76; see Table 4 footnote.[6]) If one identical twin has same-sex sexuality with nonconforming gender expression, the other usually has neither. (Bailey et al., 2016, pp. 76). If one twin lives as another sex, the other does also in about 28%[7] of identical twin pairs (M. Diamond, 2013, but the assessment of this rate may become lower as concordance rates are published for larger samples of twins where one is transgender-identified or lives as the other sex).

59. **Social environment affects biological factors such as epigenetic elements and genes themselves**. The genome is composed of our genes, and the epigenome is composed of the chemical environment around the genes that prevents or facilitates replicating and modifying of genes. Both genes and the epigenetic machine are influenced prenatally and postnatally by social environment. Epigenetic elements do not only turn genes fully on or fully off; they modify genes, especially genes in the brain, enabling memory, learning, and adaption to the environment lifelong. Similarities and

[6]Same-sex sexuality: Pairwise concordance of 14% calculated from probandwise concordance of 24%. *Pairwise* concordance indicates the percent of twin *pairs* in which both twins have same-sex sexuality. *Probandwise* concordance tells the percent of *individual* twins who have a twin that has same-sex preference. Example: If 100 pairs of twins have at least one twin that has same-sex preference, and if in 14 of those pairs, both twins have same-sex preference, then 114 individual twins have same-sex preference and 28 individual twins have a twin who has same-sex preference. 28/114 = about 24% of individual identical twins who have same-sex preference have a twin who has same-sex preference. For probandwise concordance = 24%, see caption under Table 4 on p. 75 in Bailey et al, 2016.

[7] I have corrected the 20% pairwise concordance rate given in the abstract of the Milton Diamond (2013) twin study, because it is evident from the context that it was an error, and because Table 5 shows the correct figure is 28%. M. Diamond (2013) used the older term "transsexual" which denotes a person who lives as the opposite sex.

differences between even identical twins may occur through modifications of genes, epigenetic influences, and social environmental influences. Each of these influences may modify the others. The social environment influences and modifies the biological influences (such as genes, epigenetic elements) on human behaviour throughout the lifespan. (Charney, 2012) This would seem to leave open lifelong potential for same-sex behaviour or attraction and gender incongruence to develop from environmental influences and to be modified or changed through environmental influences, such as therapy that addresses environmental influences, throughout life.

60. **Psychotherapy changes the brain**. Impressively robust research has found that both the development of trauma and effective trauma treatments cause epigenome-wide changes in the brain, thus modifying genes. The researchers concluded, "…this study finds specific genes associated with treatment response, and underscores the potential of epigenetic markers related to successful treatment and symptomatic remission of stress-related disorders such as PTSD [post-traumatic distress disorder]. New is that our results indicate that trauma-focused psychotherapy does indeed change biology and that these changes can be detected by analysis of the epigenetic state across the genome. Therefore, this study also provides biological evidence for the clinical notion that psychological and biological systems interact when it comes to both development of, and recovery from PTSD." (Vinkers et al., 2019)

61. **There is broad agreement based on research that sexual attraction and behaviour and gender identity and expression are not simply biologically determined, as by genes, epigenetics, prenatal biological environmental influences such as prenatal hormones or maternal factors, or brain structures, but are also influenced by life experiences in an individual's psychological, social, and cultural environment throughout the life span.**

    a. **The American Psychological Association's *APA Handbook of Sexuality and Psychology* says,**

        "The inconvenient reality….is that social behaviours are always jointly determined" by nature, nurture, and opportunity (Kleinplatz & Diamond, 2014, in APA Handbook, vol.1, chapter 9, p. 257).

        "Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors." (Rosario & Schrimshaw, 2014, vol. 1, chapter 18, p. 583).

        "It [transgender identity] is most likely the result of a complex interaction between biological and environmental factors". (Bockting, 2014, vol. 1, chapter 24, p. 743)

    b. **The Royal College of Psychiatry (2013)** says same sex sexuality develops from biological and environmental influences.

c. **At least 16 professional organisations around the world, including 10 endocrine societies internationally, agree that incongruent gender identity develops from a mixture of biological influences and life experiences in the social environment. These organisations include** the Endocrine Society and 6 organisations that co-sponsored its Guideline: the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, World Professional Association for Transgender Health (WPATH)" (Hembree et al., 2017; hereafter, I will refer to these organisations as the Endocrine Society and its 6 co-sponsoring organisations). Additional organisations are those that published a highly regarded global consensus statement, the "Global Disorders of Sexual Development Update since 2006: Perceptions, Approach and Care": the Asian Pacific Pediatric Endocrine Society, Japanese Society of Pediatric Endocrinology, Sociedad Latino-Americana de Endocrinologia Pediatrica, Chinese Society of Pediatric Endocrinology and Metabolism (also again the European Society for Pediatric Endocrinology and the Pediatric Endocrine Society that participated in both the global consensus statement and the Endocrine Society Guideline) (Lee, Nordenstrom et al., 2016). More organisations are the American Psychiatric Association (DSM-5-TR, 2022, p. 511), American Psychological Association (Bockting 2014, in *APA Handbook*, vol. 1, chapter 24, p. 743), American Academy of Paediatricians (Rafferty, 2018, p. 4), British Psychological Society (Shaw et al., 2012, p. 25) and the Royal College of Psychiatry (2013).

d. **The final Cass report for NHS England accepts that gender dysphoria or incongruence likely develops from a complex interaction of biological and social influences.** (Cass, April 2014)

> **8.52 There is broad agreement that gender incongruence is a result of a complex interplay between biological, psychological and social factors.** This 'biopsychosocial' model for causation is thought to account for many aspects of human expression and experience including intelligence, athletic ability, life expectancy, depression and heart disease. (p. 121)
>
> **8.54** Although we do not have definitive evidence about biological causes of gender incongruence it may be that some people have a biological predisposition**. However, other psychological, personal and social factors will have a bearing on how gender identity evolves and is expressed**. p. 122)

62. The invalid view that same-sex sexuality and incongruent gender identity are biologically determined is often the underpinning for the view that these experiences cannot change or cannot change through therapy, so change-allowing therapy can only be futile and harmful and should be censored.

63. **To summarise, biological explanations for same-sex sexuality or gender incongruence are largely based on the idea that biological influences may cause a girl to be born more masculine or a boy to be born less masculine, but being less masculine or more masculine does not equal same-sex sexual attraction or an incongruent gender identity. Therefore, these theories of biological influences taken alone cannot explain the development of same-sex sexuality or gender incongruence**. **Exhibiting gender atypical tendencies may, however, lead to *life experiences*** in relationships that may lead to same-sex sexuality or to dis-identifying with one's sex and identifying with another sex. Even if it is proved that genetic or prenatal influences cause some boys to be born less masculinised, it would not prove prenatal biological influences simply and directly cause same-sex attraction feelings or discordant gender identity feelings. It is not the case that all boys who are gender atypical develop same-sex attraction or incongruent gender identity or expression, just as not all boys who are tall become basketball players. And there is some research suggesting gender atypical behaviour may not always persist into adulthood. (Zucker, 2005, p. 488) There is a distance between less masculine or more feminine tendencies or characteristics on the one hand and same-sex sexual attraction feelings or incongruent gender identity or expression on the other hand that has to be traversed. There have to be additional influences, and some obvious candidates would be *effects resulting from* a boy presenting as less masculine or more feminine. For example, parents, older brothers, peers, teachers, and others may be primed to assume a boy who is less masculine in stereotypical ways will have same-sex attraction or incongruent gender identity, an assumption that is not uniformly true (Bockting, 2014, in *APA Handbook*, vol. 1, chapter 24, pp. 743-744) but that may itself influence social expectations and responses that may themselves shape a boy toward those ends. Correspondingly similar effects may befall more masculine girls.

64. **Some clients who have sought and benefitted from therapy conversations that are open to change have said they felt others perceived them as different from their same-sex peers, and the responses of others became influences in their development of same-sex sexuality.** For example, some boys felt others perceived them as different from other boys—whether in appearance, in having less athletic ability, in having interests such as art, music or drama, in having a more sensitive or intuitive temperament. Some felt their father, older brother(s), other boys, and girls rejected them, bullied them, and called them "gay," affecting their gender self-esteem as a boy, isolating them, leaving them with a longing for male affirmation that became sexualized around puberty or thereafter and shaping them toward same-sex sexuality. They felt it was responses of others in relationships or sexual or gender trauma, rather than their gender-atypical traits per se, that influenced their sexuality or gender identity. (Nicolosi, 2009, for examples pp. 41-44) Some clients have said they had other influential experiences not necessarily related to any gender traits. Our clients wanted counselling conversations that helped them explore and resolve sexual or gender trauma and relational wounds they felt were underlying sexual and gender feelings, and many, though not all, reported that shifts or changes in sexual or gender feelings or behaviours resulted as a by-product.

65. **Causal direction may go the other way, too. That is, life experiences may lead to gender nonconforming behaviour, possibly accompanied by same-sex sexuality or gender discordance.** Some clients who have sought change-allowing therapy have reported that their early experiences in their family led them to reject gendered behaviour associated with their own sex. Some said they saw men as aggressive and women as weak, or vice versa, and felt they did not want to be like their same-sex parent or members of their sex. Some recounted adult roles they saw or perceived for their own sex that frighted them. Some reported very early challenges in bonding with their same-sex parent. Some felt they would be more valued or safe presenting as or even identifying as another sex.

66. **Child development is largely missing from biological views of causes of sexual orientation (Diamond, 2023) or gender identity, except for a focus on childhood gender-nonconformity.**

67. **Models of child, adolescent, and adult development, including for sexuality and gender identity, should include social and psychological life experiences throughout the lifespan, experiences that are the domain of psychotherapy.**

V. SAME-SEX ATTRACTION, BEHAVIOUR, AND IDENTITY MAY CHANGE THROUGHOUT THE LIFESPAN

68. **The APA Report (2009), recommending LGB-identity-affirming therapy and discouraging any kind of "sexual orientation change efforts" ("SOCE"), claimed its conclusions and recommendations were based in part on what the task force characterised as a "key" scientific finding that sexual orientation does not change through life events** (pp. 63, 86). If this presumed scientific finding were true, then facilitating "sexual orientation" change through therapy would be impossible and attempts at doing so would only fail and potentially harm people and shame them when they failed to change. In fact, that has been the exact claim being made by numerous LGBT identity activist groups pushing for therapy bans.

    a. **However, five years after the APA Report made these claims to discourage any change-allowing therapy, the *APA Handbook of Sexuality and Psychology* (*APA Handbook*), which the APA declared "authoritative" and to which the APA gave its "imprimatur" (Vandenboss, 2014), contradicted these claims in that it actually recognised research shows that sexual attraction, behaviour, and orientation identity all commonly change for adolescents and adults, males and females, over the life course. The *APA Handbook* says,**

> **[R]esearch on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attraction, behaviours, or [orientation] identities over time."** (Diamond, 2014, in *APA Handbook, vol. 1*, chapter 20, p. 636)
>
> **Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view**

of consistency in sexual orientation." (Rosario & Schrimshaw, 2014, in *APA Handbook, vol. 1*, chapter 18, p. 562)

Over the course of life, individuals experience the following: …changes or fluctuations in sexual attractions, behaviours, and romantic partnerships…." (Mustanski, Kuper, & Greene, 2014, in *APA Handbook vol. 1*, chapter 19, p. 619)

b. **Also, in 2021, the American Psychological Association officially acknowledged in a position statement that sexual orientation traits change for some.** The APA recently affirmed again that "fluidity describes changes in awareness, attractions, behaviours, and identities that unfold over time", and "sexual orientation can evolve and change for some…." These admissions were in the APA's 2021 resolution on sexual orientation change efforts. (APA, 2021)

c. **The American Psychiatric Association (2019b) concurs that "sexual orientation" may "change over time".**

d. **The changing statements on sexuality by the Royal College of Psychiatrists and varying statements within the American Psychological Association show views in professional organisations can evolve and dramatically change and do an about face. The eminence of professional organisations cannot replace the evidence of research, to which the discussion now turns.**

69. **Research into change in sexuality experiences must take into account their complexities.**

a. **One common popular concept is that most people simply are either exclusively homosexual in sexual attraction, sexual partners, and orientation identity from birth to death or exclusively heterosexual in sexual attraction, sexual partners and orientation identity from birth to death. If that were the case, the viewpoint that people can never change and can never change through therapy would make sense. Same sex sexuality, however, is far more complex than that.**

b. **For example, most same-sex attracted people by far are both-sex attracted.**

i. **This has been found documented in rigorous population representative and cohort studies.** (Diamond, 2014, in *APA Handbook, vol. 1*, p. 633; nationally representative studies: Savin-Williams, Joyner, & Reiner, 2012 and Kahn & Halpern, 2019, p. 11; Laumann et al., 1994, Table 8.3B on p. 311; Mosher, & Copen, 2011, Table 11; Mosher, Chandra, & Jones, 2005, Table 17; Hayes et al., 2012, Table 2; Large cohort studies of New Zealanders: Dickson, Paul, & Herbison, 2003; Dickson, Roode, Cameron, & Paul, 2013. More research: Vrangalova & Savin-Williams, 2012)

ii. **The American Psychological Association's *APA Handbook of Sexuality and Psychology* accepts,** (Diamond, 2014, in *APA Handbook, vol. 1*, p. 633)

> Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical "type" of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true: Individuals with nonexclusive patterns of attraction are indisputably the "norm," and those with exclusive same-sex attractions are the exception.

c. **Further, studies have found that a person who experiences one same-sex sexuality trait, such as same sex attraction, behaviour, or identity, *usually does not* experience all these traits. Researchers studying change must take care to designate which sexuality traits they are studying. (Diamond, 2003)**

i. **U.S.: A nationally representative study found that among men and women who experienced any same-sex sexuality traits of attraction, behaviour, or identity, 76% of men and 85% of women did *not* have all three traits present.** The most comprehensive study of sexuality ever conducted in the U.S., the National Health and Social Life Survey, was among the first to report that, for people who report any same-sex sexuality, traits of same-sex sexuality for desire ("appeal" and "attraction"), sex partners after age 18, and identity (homosexual, bisexual, or an equivalent) are usually not all present. These traits were present at the rates shown below in a representative study of 3,432 U.S. adults (p. 63) ages 18 to 59 years. (Laumann et al., 1994, p. 299)

> **<u>Men</u>: <u>presence</u> of same-sex or bisexual traits among men who experienced <u>any same-sex sexuality:</u>**
> (Total is slightly less than 100% because figures are rounded.)
> 44% Desire only
> **24% Desire, behaviour, identity (all 3 traits)**
> 6% Desire, behaviour only
> 1% Desire, identity only
> 0% Behaviour, identity only
> 22% Behaviour only
> 2% Identity only
>
> **<u>Women</u>: <u>presence</u> of same-sex or bisexual traits among women who experienced <u>any same-sex sexuality:</u>**
> (Total is slightly more than 100% because figures are rounded.)
> 59% Desire only
> **15% Desire, behaviour, identity (all 3 traits)**
> 13% Desire, behaviour only
> 1% Desire and identity only

0% Behaviour and identity only
13% Behaviour only
0% Identity only

ii. **Britain: Similarly, a nationally representative study in Britain found that among men and women who experienced any same-sex sexuality traits of attraction, behaviour, or identity, 74% of men and 85% of women did *not* have all three traits present.** These data are reported in a secondary data analysis of the National Survey of Sexual Attitudes and Lifestyles (Natsal-3) that surveyed 15,162 people, ages 16 to 74, in Britain from 2010 to 2012. (Sullins & James, 2022, Table 2, these descriptive statistics from a secondary analysis of the data that is not peer-reviewed)

Men: presence of same-sex or bisexual traits among men who experienced any same-sex sexuality:
(Total is a little less than 100% because figures are rounded.)
34% Desire only
26% Desire, behaviour, identity (all 3 traits)
15% Desire, behaviour only
2% Desire, identity only
<1% Behaviour, identity only
18% Behaviour only
2% Identity only

Women: presence of same-sex or bisexual traits among women who experienced any same-sex sexuality:
68% Desire only
14% Desire, behaviour, identity (all 3 traits)
8% Desire, behaviour only
5% Desire and identity only
<1% Behaviour and identity only
4% Behaviour only
1% Identity only

iii. **Similar differences in attraction, behaviour, and identity have been found in more studies in the U.S. and in Australia and Norway. (American Psychiatric Association, 2019, graph on p. 1; research discussion on this: Li, Katz-Wise, & Calzo, 2014)**

iv. **The portion of the population in Britain that reported lesbian, gay or bisexual *identity* was far smaller than the proportion reporting having same-sex *attraction* or having had same-sex *sex*. Compared to people in Britain who reported same-sex *attraction*, only 38% as many men and 21% as many women *identified* as gay or bisexual. Surveys, such as the National LGBT 2017 Survey (Government Equalities Office, 2018) of people who adopt an LGB identity may**

exclude most **people who experience same-sex sexuality traits.** Researchers reported, (Geary et al., 2018, pp. 10-11, Table 3, p. 5)

> When the survey was completed, there would have been an estimated 547,000 men who identified as gay or bisexual and this increases by 657,000 to 1,204,000 reporting ever having had same-sex sex and then to 1,423,000 for those reporting same-sex attraction. Similarly, 546,000 women are estimated to have identified as lesbian or bisexual and this increases by 843,000 to 1,389,000 ever having had same-sex sex and then to 2,618,000 for those reporting same-sex attraction. (Geary, p. 10)

> Overall, 2.5% of 16- to 74-year-old men and 2.4% of women self-identified as lesbian, gay or bisexual; 6.5% of men and 11.5% women reported any same-sex sexual attraction; 5.5% of men and 6.1% of women reported same-sex sex ever, and a further 2.4% of men and 5.3% of women reported same-sex experience but never with genital contact (7.9% and 11.4% in total; Table 1). (Geary, p. 5)

v. **The second largest sexuality in Britain next to heterosexual was mostly heterosexual.** Next in size to exclusively-opposite-sex attraction (93.0% men, 87.8% women) and exclusively opposite-sex behaviour (91.7% men, 88.0% women) was "more often opposite sex, at least once same-sex" attraction (4.0% men, 9.2% women) and behaviour (4.8% men, 9.3% women). (Geary et al., p. 5) People reporting mostly heterosexual attraction were greater in number than all other people reporting any nonheterosexual attraction combined, as found in large, nationally representative studies in the U.S. (Savin-Williams, Joyner, & Rieger, 2012) and New Zealand (Wells, McGee, & Beautrais, 2011. Sexual identity was defined by sexual attraction in both these studies.)

vi. **Contrary to conventional wisdom, people who experienced exclusively same-sex attraction or exclusively same-sex sex were the exception and were not representative of most people in Britain who experience any same-sex sexuality. The smallest groups** were exclusive same-sex attraction (0.9% men, 0.4% women in the general population) or exclusive same-sex sex (0.7% men, 0.2% women in the general population). Among these who reported only or more often *attraction* to people of the same sex, only a small minority reported they *had sex* only with the same sex (37.8% men, 14.6% women). (Geary, Table 3 and p. 5)

d. **Thus, the U.K. and U.S. studies found that it is the exception that individuals who have had same-sex sexuality experiences have experienced only and**

always all of the following: exclusive same-sex attraction, exclusive same-sex partners, and exclusive homosexual identity.

e. **To further highlight how different same-sex sexuality is from some popular perceptions, these studies found that, among people in the U.K. and U.S. who experienced same-sex *attraction*, most did not take an LGB identity, and some did not engage in same-sex sex.**

70. **Among both adults and adolescents who experience any same-sex sexuality traits, there is the added complexity that sexual *attraction, behaviour, or identity* may each be directed toward a different sex—such as the same-sex, the opposite-sex, both sexes, or no sex—and therefore m*ay not match* within the same person either at the *same time* or *over time*. This has consistently been found for adolescents and adults across many studies.** (Kaestle, 2019; Calatrava, Sullins, & James, 2023; Wells, McGee, & Beautrais, 2011; discussion in Fish & Russell, 2018, example p. 1054) For example, a person may experience both sex attraction, only engage in same-sex sexual behaviour, and identify as heterosexual. **Each of these traits—attraction, behaviour, or identity— may *not match* and may *change independently* of others within the same person.**

71. **Further adding to the complexity, someone having same-sex attraction or behaviour cannot tell us how much they may also have opposite-sex attraction or behaviour and vice versa. It is best for researchers to measure same-sex experiences separately from opposite-sex experiences. Most researchers, however, have used a continuum scale from same-sex to opposite-sex to measure sexual attraction or behaviour.** Researchers who conducted the largest-ever gene study concluded that "there is no single continuum from opposite-sex to same-sex sexual behavior." (Ganna et al., 2019a) They said, **"[I]t is an oversimplification to assume that the more someone is attracted to the same sex, the less they are attracted to the opposite sex."** Ganna et al., 2019b, bold added; see also Zietsch et al., 2012, p. 10; Vrangalova & Savin-Williams, 2012)

72. **An additional complexity is that sexuality identity self-label may mean different things. It may be based on attraction, behaviour, political or community factors, or simply how individuals perceive themselves (not further defined). Researchers who study identity must clarify how they are defining identity for their research participants.** (Rosario & Schrimshaw, 2014, in *APA Handbook, vol. 1*, pp. 555-559; Wells, McGee, & Beautrais, 2011, p. 156) Political or community factors for taking a same-sex sexuality identity may include sharing opinions or viewpoints on same-sex sexuality, sexual permissiveness, sex without love, or political viewpoints or activism. (sexual , Sullins, & James, 2023 analysis of data from Natsal-3, 2010, sexual attitudes; see Diamond, 2014, *APA Handbook, vol. 1*, Chapter 20, political factor especially on pp. 631-632; Fergusson et al., 1999, self-perception or behaviour on p. 877; Savin-Williams, Joyner, & Reiger, 2012, attraction on pp. 105-106; Wells, McGee, & Beautrais, 2011, orientation defined as attraction on p. 157, but others have defined it as recent sexual behaviour, p. 156)

73. **Same-sex sexuality experiences are messy or complex and do not necessarily fall into categories of sexual orientations. This raises the question, what does "sexual orientation" mean, and how can researchers measure it or measure change in it? How can therapists know what the MoU forbids them to help anyone change?**

    a. **Same-sex sexuality is neither an orderly nor a static trait that comes in coherent, reliable orientation categories that have clear cut points. Instead, same-sex sexuality is an array of messy, often mismatched, commonly changing experiences. Authors of the highly regarded and most comprehensive study of adult sexuality in the U.S. said, "in short, neither pedantry nor extreme scientific cautiousness leads us to assert that estimating a single number of the prevalence of homosexuality is a futile exercise because it presupposes assumptions that are patently false: that homosexuality is a uniform attribute across individuals, that it is stable over time, and that it can be easily measured."** (Laumann et al., 1994, p. 283. See discussion in *APA Handbook of Sexuality and Psychology:* Diamond, 2014, vol. 1, Chapter 20, pp. 629-652; also discussion in Diamond & Rosky, 2016, p. 365; Diamond, 2023)

    b. **How does one, for example, coherently define "homosexual orientation"?** What amount of same-sex attraction feelings define a homosexual orientation? Is it one moment of same-sex sexual attraction feeling in one's lifetime? A month, a year, lifelong? Does there have to be same-sex behaviour? If so, how much? Once, sometimes, predominantly, exclusively? Do the degrees of attraction and behaviour need to match? What if attraction feelings or behaviours change at different times and rates? What if same-sex feelings or behaviours occurred only in youth and never again (Laumann et al., 1994, p. 296), only beginning in mid- or late-life, only ever with one specific person, only after choosing same-sex preference for social or political reasons (Diamond, 2014, *APA Handbook*, Chapter 20) or only when under distress? (Potts et al., 2008, p. 21) Does the person have to take an "orientation" identity? Does an identity, if the person has one, need to match sexual attraction? Behaviour? Both? What if an "orientation" identity self-label changes independently of attraction or behaviour? Are some same-sex behaviours not part of a sexual orientation?

    c. **Researchers have regarded the term "orientation" as difficult to define or measure.** (Lauman et al., 1994, p. 283; Diamond & Rosky, 2016, p. 385; Diamond, 2023) **Some researchers have suggested forsaking "the general notion of 'sexual orientation' altogether" and instead assessing "only those components relevant for the research question."** (Savin-Williams & Ream, 2007) **Researchers generally indicate what aspects of sexuality traits or experiences they are observing for their particular purpose.** (Wells, McGee, & Beautrais, 2011)

    d. **Research on sexuality change generally measures separately the amount of sexuality traits under study, most commonly (1) sexual or romantic**

attraction feelings, desire, or fantasies toward the same or opposite sex, (2) sexual behaviour, partners, or relationships with the same or opposite sex, or (3) an identity self-label for how one thinks of oneself in terms defined by the researcher that may be one's view of oneself not further defined, attraction, behaviour, or community or political factors. Researchers then assesses changes on the selected sexuality trait over time, as will now be seen in the following studies with rare exception. (Rosario & Schrimshaw, 2014, in *APA Handbook, vol. 1*, pp. 555-559)

74. **Rigorous studies of sexuality and gender identity change may use these methods:** A **population-based** study looks at observations of everyone in a population or region, such as in government census statistics in the U.K., or it observes members selected from the population in such a way as to be accurately **representative** of a whole population. A **cohort** is a group of people who share a characteristic, such as all adolescents in a gender clinic or all twins whose parents registered them in a community study when the twins were young. A **longitudinal** study measures the same characteristic in participants at more than one time and may detect whether there was change, such as change in sexual attraction over the course of life experience or during therapy. In a **prospective** longitudinal study, researchers select the participants before any develop the trait to be studied and observe who develops the trait and what factors are associated with that development. For example, they observe twins from infancy through young adulthood to observe who has adverse childhood experiences and who develops same-sex sexuality.

75. **Abundant, rigorous r*esearch* has established in the U.K. and internationally that same-sex attraction, behaviour, and identity commonly change through life experience. Change occurs for adolescents and adults, males and females. Several of the studies finding this were large (1,000 to more than 22,000 participants), population-based or cohort-based, and longitudinal (6 to 10 years) studies that used a Kinsey scale of at least 5 points to measure degrees of same- and opposite-sex *attraction*.** (Dickson et al., 2003, Figure 1; Dickson et al., 2013; Hu & Denier, 2023b; Hu, Xu, & Tornell, 2015; Kaestle, 2019; Mock & Eibach, 2012; Ott et al., 2011; Savin-Williams, Joyner, & Rieger, 2012). **One complex nationally representative data reanalysis study examined relationships of attraction, behaviour, and identity in close to 7,000 participants for up to 13 years.** (Kaestle, 2019) **An even larger population-based study in the UK looked at sexual *identity* change over the lifespan. (**Hu, Xu, & Tornell, 2015)

    a. **A study of 22,673 people that is representative of the population in the United Kingdom found that over a 6-year period from 2011-2013 to 2017-2019, a significant minority of people reported change in their sexual *identity*—7% of the national population. (Hu & Denier, 2023b) Within these, only 3% of heterosexuals reported sexual identity change, while 16% of gay or lesbian-identified people, a majority of bisexual-identified people—57%, and 85% of "other" sexual identified people reported change. The researchers said the identity change found across age groups extended to the elderly and "calls into question the linear assumption that sexual identity**

'stabilizes' over the life course. Rather than narrowly focusing identity change research on adolescence as "a critical stage of sexual identity development", the researchers said, "our findings suggest that changes in sexual identity reports represent an equally worthy research topic among the elderly and indeed across the full life span." They said those who set policies for people of these identities "need to account for the fact that their target populations are very much in flux." (pp. 670-671)

b. **One of the most detailed data sets we have on sexual *attractio*n change is from a rigorous, large, nationally representative, longitudinal study in the U.S. of sexual attraction change over a period of 6 years from about age 24 to about age 36.** "Sexual identity" was defined by sexual *attraction*. (Savin-Williams, Joyner, & Rieger, 2012, pp. 105-106)

   i. **Among all same-sex attracted participants, 43% of men and 50% of women reported a change of at least one step** in either direction along a continuum (Kinsey scale) that ranged from exclusively heterosexual (only attracted to the opposite sex), to mostly heterosexual (mostly attracted to the opposite sex but somewhat attracted to the same sex), to bisexual (equally attracted to both sexes), to mostly homosexual (mostly attracted to the same sex but somewhat attracted to the opposite sex), to exclusively homosexual (only attracted to the same sex). (Calculated from Savin-Williams, Joyner, & Rieger, 2012, Figure 1; Diamond & Rosky, 2016, p. 7 and Table 1)

   ii. **Among all same-sex-attracted participants who reported any change, the vast majority changed toward or to heterosexual (78% of men, 83% of women). In fact, of those who changed, two-thirds (68% of men, 67% of woman) changed to *exclusive* heterosexual attraction**. (Calculated from Savin-Williams & Reiger, 2012, Figure 1)

   iii. **Among those who experienced bisexual attraction, nearly three-quarters (72% men, 73% women) reported some change in some direction.** (Savin-Williams, Joyner, & Reiger, 2012, abstract, p. 108, only one-quarter were stable; percents of bisexuals who changed calculated from Figure 1)

   iv. **The study found that, "The second largest identity group, 'mostly heterosexual,' was larger than all the other non-heterosexual identities combined."** (Savin-Williams, Joyner, & Reiger, 2012, abstract, p. 106; also Geary et al., 2018, p. 5; especially for women: Diamond, 2014, in *APA Handbook*, Chapter 20, pp. 634-635)

   v. **"Over time more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality."** (Savin-Williams, Joyner, & Reiger, 2012, p. 106)

vi. **Even 9% (8.8%) of exclusively homosexually attracted men came to experience opposite-sex attraction through life experience—about 1 out of 11 exclusively homosexual men,** with 7% changing to exclusively heterosexual and the 2% remainder to bisexual. (Savin-Williams, Joyner, & Reiger, 2012, calculated from Figure 1 on p. 107)

vii. **Also, even among exclusively lesbian women, more than 1 in 4, 27%, came to experience opposite-sex attraction through life experience—** with about half of these changing to exclusively heterosexual (13%) and the remainder about evenly divided between mostly heterosexual or bisexual. (Savin-Williams, Joyner, & Reiger, 2012, calculated from Figure 1 on p. 107)

c. **Even men who have exclusively same-sex behaviour may have at least some opposite-sex attraction.** This is according to a methodologically sophisticated study in the U.S. that was able to account simultaneously for the traits of sexual attraction, behaviour, and identity. In the emerging class of gay males who had reached their late 20's, 94% reported only same-sex *relationships*, while *attraction*s were "almost exclusively" same-sex (89%) or both-sex (11%). Sexual *identity* grew to be over three-quarters homosexual, 21% mostly homosexual, and 2% bisexual. The study was nationally representative of the U.S. population, analysing these multidimensional processes in 6,864 participants over 4 time-waves of the "Add Health" longitudinal data set. (Kaestle, 2019, p. 817) **This evidence indicates that a notable minority of homosexual-identified men experience opposite-sex attraction and some experience opposite-sex relationships. That is, in exclusively homosexual identified men, identity, attraction, and behaviour may not match.**

d. ***Several* rigorous studies have established high rates of change to exclusively heterosexual attraction**. Across several large, nationally representative or cohort, longitudinal studies, 26% to 45% of non-heterosexual men and 46% to 64% of non-heterosexual women experienced change along the Kinsey scale. Of these who changed, 50 to 100% of men and 55 to 91% of women changed to exclusively heterosexual. (Some studies defined identity as attraction. Diamond & Rosky, 2016, p.7, Table 1; Savin-Williams et al., 2012; Ott et al., 2011; Mock & Eibach, 2012; Dickson et al., 2013)

e. **Before the APA Report (2009) and *APA Handbook* (2014) were published, it had been known that the idea same-sex attraction does not change is false. As early as 1994,** the most comprehensive study of sexuality ever conducted in America, previously referenced in this discussion, a nationally representative study that is highly regarded and cited several times in the *APA Handbook of Sexuality and Psychology*, concluded that the assumption that same-sex sexuality is "stable over time", or does not change, is "false". It also reported that 42% of males who experienced same-sex behaviour before age 18 never experienced it again. (Laumann et al., pp. 283, 296).

76. Changeability is as well-recognized and as truly scientifically demonstrated a characteristic of same-sex sexuality (or "orientation") as are same-sex attraction feelings, sexual behaviour, and orientation identity. Not everyone who experiences any same-sex sexuality has all of them. Forbidding exploration of changeability makes as much sense as forbidding exploration of attraction, behaviour, or identity. It should be up to the client and therapist to decide collaboratively whether and what sexuality aspects may be explored.

a. **What studies on change establish is that same sex attraction, behaviour, and identity commonly change for men and women, for adolescents and adults, and throughout the life span, contrary to the APA task force report (2009) that sexual "orientation" does not change through life events.**

b. **The social science research evidence that sexual attraction, behaviour, and identity commonly change further adds to the evidence that same-sex attraction and behaviour are not simply inborn, biologically determined, fixed, or who someone biologically is.**

c. **A person may not know aspects of their sexuality are either fluid or changeable until they explore their sexuality. Their sexuality may not be what they believe is their "true" or "fixed" "orientation". A therapist also may not know characteristics of a person's sexuality until the therapist speaks with the person.**

d. **Among people who present as having same-sex sexuality, many discover, through exploring their potential for fluidity or change in their sexuality in therapy, that they have less same-sex sexuality and/or more opposite-sex sexuality than they had foreseen. A therapist may not know this about a client's sexuality until exploration takes place. A therapy ban presumes sexuality at presentation represents the person's authentic sexuality, and it will not change through exploration. Exploration of sexuality must be permitted to be open-ended. That is, it must be open to exploring all well-recognised aspects of sexuality, including changeability. It must be open to change, must be change-allowing.**

e. **A partial change can change a life and may enable an individual to achieve a goal to live in a procreative relationship or to be abstinent more comfortably. Categorical change to exclusively heterosexual is generally not required.**

77. Therapists, clients, and researchers should be able, in principle, to identify *life experiences* that are leading to changes, especially for both-sex attracted individuals who most commonly experience change. In fact, we do have research evidence into some relational life experiences leading to these changes.

a. **Research has overwhelmingly substantiated that, in both the U.K. and the U.S., *most* individuals who experience both-sex sexuality and some who**

experience predominantly same-sex sexuality are in *opposite*-sex relationships.

i. **Among LGB identified people, having sexual partners of the opposite sex is prevalent.** A study by the National Center for Health Statistics of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services for the first time pooled findings on 110,235 men and 132,353 women from multiple years of three nationally representative studies of adults—the National Health and Nutrition Examination Survey (NHANES, 2005-2018), the National Survey of Family Growth (NSFG, 2013-2018), and the National Health Interview Survey (NHIS, 2013-2018). The researchers found that more bisexual-identified men had had sex with the opposite sex (87%) than with the same-sex (70%), and more bisexual women had had sex with the opposite sex (97%) than with the same-sex (78%). They also found that a slight majority of gay-identified men (51%) and three-quarters of lesbian-identified women (75%) had had sex with the opposite sex. A small percentage of gay (6%) and lesbian (9%) identified adults had not had sex with the same sex. A small percentage of heterosexual-identified men (3%) and women (12%) had had sex with the same sex. (Heslin & Alfier, 2022, Tables 3 and 4)

ii. The definitive document in the U.K., Office of National Statistics, Sexual Orientation, UK (2012-2020), found that in 2020, 17% of "*bisexual" identified* people were married, almost always, 94%, to the opposite sex, and 96% of "other non-heterosexual persons", a Census category that includes transgender people, also were married to the opposite sex. (Office of National Statistics (ONS), 2012 to 2020, Table 5b)

iii. In the U.K. in 2020, among *"gay and lesbian" identified* individuals, 18% were married, 13% to the same sex and 5% to the opposite sex. Put another way, among "gay and lesbian" identified people *who were married*, a little less than three quarters (72%) of them were married to the same-sex, and a notable minority, over one quarter, 28%, were married to the opposite sex. (ONS, 2012 to 2020, Table 5b)

iv. **In the U.K. in 2020, of all LGBTQ+ identified persons taken together, 65% who were married were with the opposite sex. Thus, 255,000 LGBTQ+ identified persons in the U.K. were in opposite-sex marriages, comprising 41% of all LGBTQ+ identified people who were not single. (Sullins, March 2024)**

v. A U.K. nationally representative, longitudinal survey, the United Kingdom Household Longitudinal Study (Understanding Society or USOC) found that in 2011 to 2013 and 2017 to 2019, 70% of individuals

who identified as bisexual were *in a relationship*, 86% of them with the opposite sex. (Hu & Denier, 2023b; 2023a, Table A4)

vi. In the U.S., a nationally representative study found that, of bisexual-identified men and bisexual-identified women who were in any relationship, the vast majority were in an opposite-sex relationship (88% of bisexual men and 90% of bisexual women). (Herek et al., 2010, Table 8)

vii. In a secondary analysis of a U.S. nationally representative longitudinal study (known as the "Add Health" study conducted in 4 waves from 1995 through 2009), most both-sex attracted individuals, ages 16 to 32, who were in a relationship were with the opposite sex. About two thirds of "mostly straight" and bisexual men in their late 20's were in opposite-sex relationships. For women, more than 85% of "mostly straight" and more than 70% of bisexual women in their late 20's were in opposite-sex relationships. The study employed a multidimensional approach that took into account attraction, activity, and identity. (Kaestle, 2019, figure 3 and p. 819)

viii. A recent U.S. nationally representative Gallop survey found that more than half of LGBT-identified adults in the U.S. identify as bisexual, and "Bisexual adults are overwhelmingly likely to be married to, or living with, someone of a different sex (32%) rather than someone of the same sex (5%)." For all LGBT-identified adults—not only including bisexual identified but also including gay and lesbian identified—who are married in the U.S., roughly equal proportions are married to the opposite sex (11%) as are married to the same sex (10%). (Jones, 2022, pp. 5-6)

b. **Many individuals who have identified as experiencing same-sex sexuality have felt they had some "perceived *choice* about sexual orientation" (where "choice" was not further defined), perhaps meaning choice in the sex of the person with whom they had a relationship.** In the U.S., 62% of bisexual-identified men, 60% of bisexual-identified women, 12% of exclusively gay-identified men, and 32% of lesbian-identified women said they had some (a little or a fair amount of) choice, according to a U.S. nationally representative study (Herek et al., 2010, p. 186, Table 3).

i. **Some both-sex attracted individuals have chosen to be in an opposite-sex relationship because they wanted to pro-create children with their partner** (Diamond, 2008, pp. 118-119; Kaestle, 2019, p. 820) or because they wanted to live by their religious beliefs (Lefevor et al., 2019).

ii. **"[T]he formation of emotional attachments may facilitate unexpected changes in sexual desire".** (Diamond & Rosky, 2016)

Some women in a 10-year study just fell in love with a person of the opposite sex unexpectedly. (Diamond, 2008, p. 8)

iii. **Choice of a predominantly LGBT or predominantly heterosexual social environment may influence opportunities to meet more people of the same or opposite sex**. For example, an LGB social network where the same sex predominates or a work environment where the opposite sex predominates may be a factor in whether a both-sex attracted person enters a same or opposite-sex relationship. (Diamond, 2008, pp. 114-118; Diamond, 2014, Ch. 20, in *APA Handbook;* Diamond & Rosky, 2016, p. 8; Pomeroy, 1972, pp. 76-77)

c. **Sexual abstinence by same-sex-attracted people is associated with sexual attraction shifts for some.** Researchers who studied same-sex attracted people across 4 time points in a U.S. longitudinal data set reported **"**that people who report same-sex attraction with no relationship or an opposite-sex partner were more likely to shift their same-sex attraction than those who reported a same-sex relationship." (Hu, Xu, & Tornello, 2016, p. 658)

d. **More conservative religious than liberal religious or nonreligious people who experience same-sex sexuality were found to live in opposite-sex relationships or to be abstinent,** according to a research team that is ideologically diverse (in political views, religion, sexual orientation, and preferred views on LGBT-identity-affirmative therapy and change-affirmative therapy) that studied Mormon same-sex attracted people. (Lefevor, Beckstead, et al., 2019) A traditionally religious social network may influence *choice* of *opposite*-sex relationships or abstinence or may predominantly provide *opportunity* for *opposite*-sex relationships. A religiously liberal or nonreligious social network may influence *choice* of *same*-sex relationships or may provide more *opportunity* for *same* sex relationships.

e. **Desire to maintain or enter an opposite-sex marriage is one of the most common reasons given for seeking *therapy* to explore potential for sexual attraction shift or change**. Some want to decrease same-sex attraction and/or increase opposite-sex attraction to avoid temptations to stray, protect their marriage to the person they love, and enable them to go on being full-time mums and dads—all more easily and enjoyably. Some who are single aspire to marry and procreate children with their future spouse. (Pela & Sutton, 2021; Sullins & Rosik 2024; Karten & Wade, 2010)

f. **There is research evidence that, for both-sex attracted individuals, experiences of satisfying opposite-sex relationships may lead to an increase in opposite-sex fantasies and decrease in same-sex interest, especially for women.** (Diamond, 2008, pp. 114-118; Diamond, 2014, Ch. 20, in *APA Handbook;* Pomeroy, 1972, pp. 76-77) **Therefore, living according to traditional religious values that favour abstinence or opposite-sex relationships, perhaps also living in a supportive church community or other**

faith-based communities that may increase opportunities for heterosexual partners, may lead to increase of opposite-sex fantasies and decrease of same-sex interest, bringing sexual attraction toward increased alignment with religious values and relationship desires for some. The opposite may also hold true. That is, for both-sex attracted individuals who are in satisfying same-sex relationships and perhaps living in LGBT communities that may increase opportunities for same-sex relationships, same-sex fantasies may increase and opposite-sex interest decrease. Patterns established may become stable. (Diamond, 2008, pp. 114-118; Diamond, 2014, Ch. 20, in *APA Handbook;* Pomeroy, 1972, pp. 76-77; Kaestle, 2019, p. 821.)

g. **As a result, it is conceivable that therapy, support groups, or communities may themselves have some degree of influence on sexuality for some individuals. This might be one influence contributing to differences found in research on groups specific to LGB-identified people and groups specific to former- and non-LGB-identified people.** Individuals who are in therapy or support groups that affirm same-sex relationships and community opportunities for them might be expected generally to experience more increase in same-sex sexuality, and individuals who are in therapy or support groups that are open to change toward opposite-sex relationships and community opportunities for them may be expected generally to experience more increase in opposite-sex sexuality.

h. **Religiously conservative individuals who experience same-sex attraction and who are in opposite-sex relationships can experience satisfaction. (Lefevor, Beckstead, et al., 2019; Yarhouse, Pawlowski, & Tan, 2003) The rate of satisfaction was 80% in a U.S. study conducted by an ideologically diverse research team**. (Lefevor, Beckstead, et al., 2019) In this study, same-sex attracted men and women who were in opposite-sex ("mixed orientation") relationships overall described their sexual attraction as both-sex attracted and leaning on the side toward predominantly homosexual but *more than incidentally* heterosexual, and those in same-sex relationships overall described their sexual attraction as predominantly homosexual and *only incidentally* heterosexual. (Table 3 and p. 11) Individuals who were single and sexually active reported more same-sex attraction than those who were single and abstinent. The authors considered that the degree of same- or opposite-sex sexual attraction may influence an individual's choice of relationship option. However, in view of other research discussed here, the opposite may also be true, that living in a same-sex or opposite-sex relationship may exert some influence on sexual attraction, and consideration should be given as to whether there is a possibility that, among single individuals, engaging in same-sex behaviour versus abstinence may affect sexual attraction.

h. **Kinsey reportedly helped some men shift to both-sex or opposite-sex sexuality by having satisfying relationships with women.** Kinsey's colleague, Pomeroy, reported that as early as 1940, Kinsey was advising men that becoming comfortable living in a heterosexual social community versus staying

in a homosexual community and gradually developing satisfying relationships with women helped some men, though not all, develop satisfying relationships with women that continued alongside same-sex sexuality or largely replaced it. Pomeroy reported on records that **Kinsey helped more than 80 men this way and at least one "homosexual boy."** Kinsey would warn that it did not always work, but, he said, "Sometimes, however, I have known the homosexual pattern to change almost overnight, as the result of a fortunately satisfactory heterosexual experience." (Pomeroy, 1972, pp. 76-77)

i. **Therapists and counsellors help people experience satisfaction in their relationships, therefore may help navigate the natural journey of shifts in sexual attractions. Therapists may assist those who have both-sex attraction and are in opposite-sex relationships where they are building satisfying relationship experiences and processing shifting in their sexual interest. Individuals in these situations should be able to seek therapy or counselling for this purpose without viewpoint discrimination. As a result of the MoU, therapists will be afraid to risk assisting clients with these relationships and shifts for fear such assistance will be labelled as "conversion therapy" and lead to their being punished by their accrediting body. The MoU, in restraining this help for clients who desire it, is unjustified and unethical.**

j. **There is *research* evidence lending support to the possibility that being in an opposite-sex relationship, being a parent in an opposite-sex relationship, and being in an orthodox religion or conservative culture may help some individuals decrease same-sex behaviour and attraction and increase opposite-sex behaviour and attraction through *therapy* that is open to such change. It is notable that *both* a randomised, controlled trial, conducted by LGB-identity-affirmative researchers, of men who have sex with men and studies of change-allowing therapy for mostly religious men found that *men who are fathers and men for whom same-sex behaviour is inconsistent with their values were particularly successful in reducing same-sex partners.***

    i. **Several sets of replicated, randomised, controlled trials found that men who have sex with men significantly decreased same-sex partners through gay culture sensitive standard therapies and retained the decrease over time**. (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Nyamathi et al., 2017) The largest and most recent of these studies identified that **men who have children and men for whom same-sex behaviour is not consistent with their values (measured by researchers as higher "homonegativity") were especially successful in decreasing same-sex behaviour.** These may be men who want to preserve their marriage to an opposite-sex spouse they love with whom they have children or who want to live by their orthodox religious or culturally conservative values. (Nyamathi et al., 2017)

ii. **A study of 125 mostly religious, same-sex attracted men in change-allowing therapy found that 69% decreased same-sex *attraction*. Among research participants, 41% were married men, most of them fathers with an average of 3 children each. They were especially successful at reducing same-sex *behaviour***. The number of married men who engaged in same-sex behaviour decreased from 71% before change-allowing therapy to 14% after therapy. (Sullins & Rosik, 2024) I will present more details of the study later.

iii. In another study of 117 mostly religious, same-sex attracted men, 42% were in an opposite-sex marriage, 9% were divorced, engaged, or separated, and 43% had children. Married men—who generally were fathers—were more successful in reducing same-sex attraction and behaviour than single men. (Karten & Wade, 2010, p. 87)

iv. In a qualitative study of 882 participants, 40% were or had been married. Among these, 32% were in an opposite sex marriage, 7% were divorced, and 1% were separated. Qualitative responses indicated that being married and having married friends were some of the influences helpful for change. Participants were 78% males, 22% females, and mostly religious. (Byrd, Nicolosi, & Potts, 2008, pp. 7, 16-17, 20)

v. In a qualitative study of 28 participants who "had been in reorientation counseling with a professional therapist and currently viewed themselves as having reoriented or as being in the process of reorienting", 55% were or had been married. (Throckmorton & Welton, 2005, p. 11)

vi. The highest ranked motivation for men in change-allowing therapy was desire to pursue a traditional marriage at 37% of participants. This was in a quantitative, prospective, 2-year longitudinal, quasi-experimental, naturalistic, repeated-measures study of Reintegrative Therapy® administered by certified Reintegrative Therapy® therapists applied for men who had a goal of sexuality change. (Pela & Sutton, 2021)

k. **It cannot be ruled out that therapy itself is a life experience and a relationship experience, and that therapy experiences and interventions may influence these changes during therapy.**

l. **Same-sex sexuality *largely develops* from life experiences and opportunities, and it *commonly changes* through life experiences and opportunities, like other traits professional therapists or counsellors help clients modify or change.** The assumption that same-sex sexuality never changes tends to be based on an invalid view that sexual attraction or behaviour is simply biologically determined.

m. **The evidence that same-sex attraction is not simply inborn and that some choices may influence opportunities for change and what direction that change may take does not mean that same-sex attraction feelings are simply a choice. Life experiences, largely unchosen, shape sexuality through developmental stages, but they may also shape it, sometimes unexpectedly, throughout the life span.**

78. **Some advocates have believed that a viewpoint that same-sex sexuality is inborn and fixed must be maintained for the purpose of political advocacy for LGB-identified people.** A leading researcher on sexuality change through life experience (not an expert on change through therapy) and her co-author, a constitutional attorney in the U.S., (Diamond & Rosky, 2016) have argued this viewpoint is "unscientific" (p. 363), has long deployed "exaggerations of scientific evidence", as in a report of "the Academy of Science of South Africa, 2015" and is "no longer necessary" in the U.S. (p. 22)

79. **The MoU and proposals for legislative therapy bans are based on the least common and most novel variant of same-sexuality, men of exclusively same-sex sexuality,** whose same sex sexuality is characterised by exclusive same-sex attraction, behaviour, and identity and who do have not experienced change.

80. **Since same-sex sexuality traits are commonly in process on a journey of change, therapy that can accompany change may be well-suited to their natural course.**

VI. DISCORDANT GENDER IDENTITY MAY CHANGE THROUGHOUT THE LIFESPAN

81. **Childhood gender dysphoria overwhelmingly resolves by late adolescence or adulthood, in about 85% of gender dysphoric children, if children are not affirmed by others as another sex** and are supported to go through natural puberty with their peers and experience the sex hormones that are natural to and congruent with their sex. (Steensma et al., 2010, p. 500)

    a. The Eleven out of 11 studies across 4 decades, from a variety of countries, and using a variety of methods have come to this same conclusion without exception (average rate of desistance 85%, range of desistance across studies 61% to 98%). (Singh, Bradley, & Zucker, 2021; Steensma et al., 2010; Ristori & Steensma, 2016; research review: Zucker 2018) A challenge to this consensus has been rebutted. (Of children who met diagnostic criteria at subthreshold, 93% desisted; of those who fully met diagnostic criteria at threshold, 67% desisted, per review by Zucker, 2018)

    b. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* and *Fifth Edition-Text Revision* published by the American Psychiatric Association accept the conclusion of these gender dysphoria desistance studies (American Psychiatric Association, DSM-5, 2013, p. 455; DSM-5-TR, 2022, p. 516; discussed in Zucker, 2018).

c. At least 9 European and U.S. professional organisations have accepted the conclusion of this research—namely the American Psychiatric Association as just stated, the Endocrine Society and its 6 co-sponsoring U.S. and European organisations (Hembree et al., 2017, p. 11), and the American Psychological Association, (Bockting, 2014, in *APA Handbook*, v. 1, chapter 24, p. 744).

d. The final Cass report accepts, "The current evidence base suggests that children who present with gender incongruence at a young age are most likely to desist before puberty, although for a small number the incongruence will persist." (Cass, April 2024, p. 223)

e. NHS England's Clinical Policy decision to stop routine use of puberty blockers for children and adolescents accepts, "Children who meet the criteria for gender incongruence / gender dysphoria may or may not continue to experience the conflict between their physical gender and the one with which they identify into adolescence and adulthood (Ristori et al, 2016)." (NHS England, 12 March 2024a)

f. Additional research not considered by the above is that 60% of children who visited the main gender clinic in The Netherlands over a span of 45 years did not go on to receive puberty blockers, one of the possible explanations being that some children resolved gender dysphoria. (Wiepjes et al., 2018)

82. **"Gender non-contentedness" in early adolescence decreased 75% by early adulthood in a population-based, prospective, longitudinal study. Researchers found, "Gender non-contentedness, while being relatively common during early adolescence, in general decreases with age and appears to be associated with a poorer self-concept and mental health throughout development."** This is from an ongoing parallel study of a general population cohort (2,229 adolescents) and a clinical cohort recruited from a large, child psychiatric outpatient clinic (543 adolescents) for comparing any psychiatric concerns, not only gender concerns. Both cohorts were from the north of the Netherlands and were studied by the same methods. Gender non-contentedness was assessed by asking participants every few years, for a total of 6 times from ages 10-12 to ages 24-26, to indicate whether they agreed with the statement, "I wish to be of the opposite sex." Three gender non-contentedness patterns were identified: no gender non-contentedness (78%), decreasing gender non-contentedness (19%), and increasing gender non-contentedness associated with female sex and participating in the psychiatric clinic cohort rather than the general population cohort (2%). Among adolescents reporting gender non-contentedness, early adolescent gender non-contentedness decreased 75% in the general population cohort and increased 28% in the psychiatric cohort by early adulthood (Rawee et al., 2014)

83. **Gender dysphoria may change throughout the lifespan—including at mid-life and later life**, according to an early British Psychological Society Guideline. "Gender dysphoria can fluctuate over years, not infrequently increasing or decreasing in mid-

life and it is not unusual for people to present for therapeutic discussion and support later in life…." (Shaw et al., 2012, p. 25)

84. **Gender dysphoria can be transitory in children, adolescents, and adults.** The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR, 2022, p. 512) lists "at least 6 months' duration" as a requirement for a diagnosis of gender dysphoria, not only for children, but also for adolescents and adults. The rationale was that "the symptoms might well prove to be transitory". Further, the fifth edition in 2013 included the option to specify the gender dysphoria was in "full remission". (Zucker, Lawrence, & Kreukels, 2016, p. 224)

85. **Even the "standards of care" of the World Professional Association for Transgender Health (WPATH) acknowledge that gender identity itself can change, even after young people have permanently altered their bodies.** Unfortunately, the Standards of Care also assert many youths find the body alterations to be a good fit for them long term, even though they also acknowledge elsewhere that their authors actually only knew of one study of long-term outcomes, but that study actually only followed youths for a little over one year. (Coleman et al., 2022, p. S66; de Vries et al., 2014) On change in gender identity, the WPATH standards of care say,

> Gender-diverse youth should also understand, although many gender-diverse youth begin gender-affirming medical care and experience that care as a good fit for them long-term, there is a subset of individuals who over time discover this care is not a fit for them (Wiepjes et al., 2018). Youth should know such shifts are sometimes connected to a change in gender needs over time, and in some cases, a shift in gender identity itself." (Coleman et al., 2022, p. S61)

And they further say,

> "Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time, and gender-related priorities at a certain point in time might change? Has the young person, to some extent, thought through the implications of what they might do if their priorities around gender do change in the future?" (p. S62)

86. **Studies of detransitioners report that even people who have had medical gender interventions have come to accept their biological sex over a wide range of ages** throughout the lifespan, as will be reviewed later. (Vandenbussche, 2021; Littman, 2021; Wiepjes et al., 2018; Dhejne et al., 2014)

87. **Desistance and detransition rates of up to 30% have been found in research. As will be discussed later, detransitioners include people who have partially or fully resolved gender dysphoria or gender incongruence. Whatever the reasons for discontinuance, unfortunately bodily harms may last a lifetime.**

a. **Southwest England: Rates of 10% to 30% medical detransition or discontinuation within 5 years** were reported among those who were trans-identified in adolescence and young adulthood (10% regret or detransition; 20% discontinuation with a mean [average] starting age of 20 and mean discontinuation time of 5 years later, range 17 months to 10 years later). (Boyd et al., 2022, p. 13)

b. **Australia: A rate of 22% desistance over 4 to 9 years** occurred in a prospective case cohort study of 79 young people referred for gender dysphoria evaluation and potential interventions at ages nearly 9 to nearly 16 and followed up at ages 13 to nearly 24. (Elkadi et al., 2023)

c. **U.K.: During only 16 months follow up on adults discharged from gender services, 7% detransitioned plus 3% partially met the researchers' criteria for detransition, there were 3 suicides (which may indicate regret), and overall 49% did not access all services they initially sought (calculated from 51% did access all the services they initially wanted). Researchers cautioned their findings were likely an underestimate of detransitioners,** saying, "as there is no automatic mechanism to inform GICs [gender identity clinics] of service users who subsequently detransition, other instances may have been missed." (Hall et al., 2021, pp. 6-7)

d. **U.S.: There was a 30% overall discontinuation rate within 4 years** for cross-sex hormone treatment in a "secondary analysis of 2009 to 2018 medical and pharmacy records of the US Military Healthcare System" for all military families domestic and abroad. (Roberts et al., 2022) Researchers identified 952 transgender people including "children and spouses of active duty, retired, and deceased military members using International Classification of Diseases-9/10 codes." (Abstract) The 4-year discontinuation rate among people who started hormones at under 18 years of age was 26%, and among those who started at or over 18 years of age was 36%. Reasons for discontinuation were unknown, but researchers said that, given the extremely minimal out-of-pocket cost for military family members, access to care was unlikely to have been a reason. (p. e3939) It is unknown whether the discontinuation rate might have been as high for those who started before 18 if they had been followed to the same age as those who started after 18.

88. **Regret historically has taken over a decade to materialise.** (Abbruzzese, Levine, & Mason, 2023, pp. 19- 20) Since rates of desistance, discontinuation, and detransition in some of the above studies were found during short follow-up studies, these rates may be greater as time since medical interventions increases.

    a. Sweden: Over 50 years (1960-2010), 2.2% applied for medical transition back to their original sex after an average of 7.5 years for female to male transgender individuals and after 8.5 years for male to female transgender

individuals. (Dhejne et al., 2014) **Application for medical retransition is a very narrow definition of detransition.**

b. **Sweden: 1972-2000: The same number as submitted regret applications committed suicide, and three times the number who submitted regret applications made documented suicide attempts**. Formal reports of regret may under-represent regret. (Zucker, Lawrence, & Kreukels, 2016, p. 237 re Dhejne et al., 2011)

c. **The Netherlands:** Among all people who attended the main gender clinic over 43 years from 1972 to 2015, **time to regret was 11 years** (10.8 years, range nearly 4 to nearly 23 years, p. 584). But **36% were lost to follow up after several years, and these may have been regretters.** These who were lost to follow up may have gone elsewhere and continued, but this clinic in Amsterdam treats 95% of gender cases in the Netherlands. **"Regret" was narrowly defined** as a patient was among those who had gone all the way to gonadectomy [removal of sex organs], then subsequently at this clinic changed hormones to match their natal sex again, and they were still living at the time of the study (p. 584). Those who regret sex surgery may not desire or pursue reversal surgery, as their regret may be hidden. Of children who attended the gender clinic, 60% did not go on to puberty blockers. Of the 40% who did persist to taking puberty blockers, 98% went on to cross-sex hormones. Of these, 78% went on to gonadectomy. This study importantly does not look at how many who had cross-sex hormones discontinued or regretted. (Wiepjes et al., 2018)

89. **Affirming transgender identity in children, as it appears the MoU accepts or may require, can be expected to decrease spontaneous change in children toward accepting their sex and result in more children persisting** to a medical protocol of serious harms, potentially followed by desistance from transition but with continuing bodily harms for life. (Zucker, 2018; 2019; Steensma et al., 2013)

    a. **Among children aged 8 years on average (range 3 to 12 years) who made a "complete" binary social transition for about 5 years, including changing their pronouns to the binary gender pronouns of the opposite sex, only 2.5% resolved gender dysphoria and came to identify with the unambiguous sex of their body**. (Olson et al., 2022)

        i. These children not only completely socially transitioned—employing all of the 4 steps of binary cross-sex clothes, hairstyle, name, and pronouns, they also were followed by an endocrinologist well before puberty began and were asked repeatedly whether they had begun puberty yet, so that, at Tanner stage 2 of puberty, they were placed on puberty blockers within months. These children not only did not *need* to anticipate puberty with anxiety, they also did not *get* to experience puberty—body changes, falling in love—did not get to find out whether the anxiety changed to feeling comfortable and even happy

with their sex. For good or for ill, they were denied their natural puberty experience. (Olson et al., 2022)

ii. Yet in the Olson et al., 2022 study, despite being completely socially transitioned to live as the opposite sex and being assigned at an early age to an endocrinologist to prevent experiencing natural puberty, 2.5% of the children completely resolved gender dysphoria and came to identity with their sex, especially if their first transgender identity occurred before age 6. Another 8.2% stopped showing up at the gender clinic the last 2 years of the study, whether formally or informally discontinuing, potentially bringing the desisters to as high as nearly 11% (10.7%).

b. The standard of care of the World Professional Association for Transgender Health (WPATH) recognises experiencing puberty is needed for the development of gender identity yet accepts nipping it in the early bud (at Tanner stage 2) with the result that children will not in fact have any impressive experience of the sex hormones natural to their sex and changes in their bodies. (Coleman, 2022, p. S64)

c. That social affirmation of a discordant gender identity may stop natural resolution and consolidate a transgender identity the child might otherwise have outgrown. (Steensma et al., 2013; Zucker, 2018; 2019) This is accepted by the American Psychological Association's *APA Handbook of Sexuality and Psychology* (Bockting, 2014, in *APA Handbook*, v. 1, chapter 24, p. 744), the American Psychiatric Association's diagnostic manual (DSM-5-TR, p. 516), and the "Guideline" of the Endocrine Society with its 6 co-sponsoring organisations (Hembree et al., 2017). Even after only partial social transition such as only using cross-sex clothing and hairstyles but not names and pronouns, a consequent second transition back to living identified as the biological sex may be substantially stressful (Steensma et al., 2013), as accepted and cautioned by the *APA Handbook of Sexuality and Psychology* (Bockting, 2014, in *APA Handbook*, v. 1, chapter 24, p. 744) and the "Guideline" of the Endocrine Society and its 6 co-sponsoring professional organisations (names of these organisations previously listed, Hembree et al., 2017, p. 11), and the final report for NHS England (Cass, April 2024, pp. 31, 164).

90. Children who are "paused" on puberty blockers rarely go on to identify with their sex. Taking puberty blockers should be viewed, not as a pause, but as the beginning of medical transition. Studies have found that 1% to 3.5% stop medical transition once started on puberty blockers. (3.5% in Brik et al., 2020; 2% in Carmichael et al., 2021; 1% in Kuper et al., 2020; 1.4% in van der Loos et al., 2023; 2% in Wiepjes et al., 2018)

91. Experiencing puberty is crucial for gender dysphoric children to come to embrace their sex, according to a qualitative study at the Gender Identity Clinic at the Amsterdam VU University Medical Centre that interviewed children who came to accept their sex. The review reported, (Steensma et al., 2010),

> …they [children at the gender clinic] considered the period between 10 and 13 years of age to be crucial. They reported that in this period they became increasingly aware of the persistence or desistence of their childhood gender dysphoria. Both persisters and desisters stated that the changes in their social environment, the anticipated and actual feminisation or masculinisation of their bodies, and the first experiences of falling in love and sexual attraction had influenced their gender related interests and behaviour, feelings of gender discomfort and gender identification.

92. **According to the Finnish government's "Recommendation", "It has been suggested that hormone therapy (e.g., pubertal suppression) alters the course of gender identity development; i.e., it may consolidate a gender identity that would have otherwise changed** in some of the treated adolescents." (Council for Choices, 2020, certified English translation, bold added)

93. **Some individuals do, nevertheless, come to identify with their sex after their bodies have already been altered and may have been irreparably harmed**. (Vandenbussche, 2021; Littman, 2021)

94. **While evidence supports that social transitioning stops the natural course of gender dysphoria resolution for children, potentially for most, it does not support that subjecting children or adolescents to this great risk improves their mental health.** The rationale for socially transitioning children or adolescents has been that it may improve their mental health. The systematic research review conducted at York University for the Cass report for NHS-England found, "Overall studies consistently reported no difference in mental health outcomes for children who socially transitioned across all comparators. Studies found mixed evidence for adolescents who socially transition." Research in this area through April 2022 was small in volume and of low quality. (Hall, et al., 2024, Impact of social transition, abstract)

95. **Dr. Cass has recommended restricting social transition and puberty blockers for children and adolescents** according to the NHS England interim report on how gender dysphoria will now be treated. The interim report did not address using cross-sex hormones with minors. The report says, (NHS England, 20 Oct. 2022)

> **Dr. Cass has recommended that social transition be viewed as an "active intervention**" because it may have significant effects on the child or young person in terms of their psychological functioning….**in most cases gender incongruence does not persist into adolescence;** and that for adolescents the provision of approaches for social transition should only be considered" [under restricted conditions and with informed consent]. (pp. 11-12)

96. **The MoU harmfully accepts affirming gender discordance at every age. It appears to deny the reality that gender dysphoria and identity may change at every age, especially if not affirmed. The seriously harmful result that can be expected is that many children and adolescents who otherwise would have resolved their gender**

discordance and lived comfortably in their bodies with reproductive health will not do so. Yet even then, gender discordance may change at every age. Affirmation harmfully denies both that gender identity and dysphoria may change and, as will be addressed next, that there may be treatable psychological causes and need for psychotherapy to resolve gender dysphoria.

VIII. DISCORDANT GENDER IDENTITY MAY HAVE TREATABLE PSYCHOLOGICAL CAUSES

97. The final Cass report commissioned by NHS-England says research suggests that adverse childhood experiences (ACEs) are a predisposing factor to gender dysphoria. It says that treating a mental health disorder that precedes gender distress and strengthening the individual's sense of self may help to address the gender-related distress. The final Cass report and its underlying commissioned research concluded:

a. **Cass report: "11.5** ….[The Review] "maintains the position that children and young people with gender dysphoria **may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. Exploration of these issues is essential** to provide diagnosis, clinical support **and appropriate intervention."** (Cass, April 2024, p. 150, bold added)

b. **Cass Report: "5.50** A review of the first 124 cases seen by GIDS (Di Ceglie et al., 2002) found that **just over a quarter of all referrals had spent some time in care and nearly half of all referrals had experienced living with only one parent.** It showed that **42% of the children** covered by the audit experienced **the loss of one or both parents, mainly through separation**; 38% had family physical health problems; and **38% had family mental health problems**. Physical abuse was documented in 15% of cases." (Cass, April 2024, p. 94, bold added)

c. **Underlying research for the Cass report: A study of the first 124 GIDS cases also found about 70% of the referrals had 5 or more associated clinical features, not just 1 or 2, and rarely were there none.** Clinical features concerned mental health, health, relationship, and other adverse experiences regarding self or family, family dysfunction, or bereavement. (Examples summarized from Table 8) Most common were "relationship difficulty with parents/carers (57%), relationship difficulty with peers (52%) and depression/misery (42%)." (Di Ceglie et al., 2002)

d. **Cass report: "8.40** Early audits and research suggest that **ACEs [adverse childhood experiences] are a predisposing factor.** This was demonstrated from the earliest audit of the GIDS service (Di Ceglie et al., 2002) and in the systematic review (Taylor et al, 2024, Characteristics of children and adolescents)." (Cass, April 2024, p. 119, bold added)

e. **Underlying research for the Cass report: A systematic review of 143 studies on children and adolescents referred to**

specialist gender services across 17 countries found, "These children/adolescents show higher than expected levels of ASC [autism spectrum condition], ADHD [attention deficit hyperactivity disorder], anxiety, depression, eating disorders, suicidality, self-harm and adverse childhood experiences." (Taylor et al., 2024, Characteristics of children and adolescents, p. 6)

f. **Cass report: 8.41** Some people rebut the notion that **trans identity may be secondary to mental health problems,** and instead suggest that the mental health problems that are observed are a response to minority stress. (Cass, April 2024, p. 119)

g. **Cass report: 8.42** The association is likely to be complex and bidirectional - that is, in some individuals, **preceding mental ill health (such as anxiety, depression, OCD [obsessive compulsive disorder], eating disorders), may result in uncertainty around gender identity and therefore contribute to a presentation of gender-related distress**. In such circumstances, **treating the mental health disorder and strengthening an individual's sense of self may help to address some issues relating to gender identity.** For other individuals, gender-related distress may be the primary concern and living with this distress may be the cause of subsequent mental ill health. **Alternatively, both sets of conditions may be associated with and influenced by other factors, including experiences of neurodiversity and trauma.** (Cass, April 2024, pp. 119-120, bold added)

98. The final Cass report says exposure to pornography from puberty onward is widespread and has led young people to expect that sex includes violence to women. Research suggests pornography is leading to sexual relational and body dissatisfaction. (Cass, April 2024) It should not be surprising if girls may not want to be women who can be subjected to such traumatic abuse and that widespread exposure to pornography has been an adverse childhood experience for girls.

7:18 Young people aged 16-21 were more likely than not to assume that girls expect or enjoy sex involving physical aggression. Among all respondents, 47% stated that girls 'expect' sex to involve physical aggression such as airway restriction or slapping, a further 42% stated that most girls 'enjoy' acts of sexual aggression. A greater proportion of young people stated that girls 'expect' or 'enjoy' aggressive sex [sic] than boys do. (Cass, April 2024, p. 110)

7:19 Several longitudinal studies have found that adolescent pornography consumption is associated with subsequent increased sexual, relational and body dissatisfaction. (Cass, April 2024, p. 110; Hanson,2020; Nadrowski, 2024)

99. The systematic research review on mental health in gender dysphoric adolescents conducted at York University for the Cass review said, (Thompson et al., 2024, p. 26)

Most papers attribute the increase in young people presenting for treatment to cultural shifts in acceptance of gender fluidity and greater availability of services. Whilst these factors are no doubt important, **this alone probably does not explain the dramatic increase in NF [natal female]** presentations: **there remains the possibility, not apparently explored in this literature, that modern sociocultural pressures associated with womanhood / femininity are influencing this generation's propensity to seek treatment.** (Bold added)

100. Government health authorities, particularly in England and other European countries, are increasingly moving away from discordant-gender-identity-affirmative treatment and prioritising psychotherapy to address influences such as psychiatric conditions or adverse experiences that may have predisposed to gender dysphoria.

a. **The Cass interim report set forth a "fundamentally different service model"** (Cass, Feb. 2022, pp. 20, 69, & this history is referenced in the final report, Cass, April 2024, p. 200) **from the "predominantly affirmative, non-exploratory approach"** (Cass, Feb. 2022, p. 17) **that had been followed at the Tavistock.** The new model will treat gender dysphoria more in line with how other paediatric psychiatric conditions are treated. (Cass, Feb. 2022, p. 69)

b. **In the month following the publication of the Cass interim report for NHS England, the National Association of Practicing Psychiatrists (NAPP) in Australia published an updated guideline that cited and very strongly concurred with this Cass report. The NAPP prioritised psychotherapy, and it issued the strongest cautions regarding use of puberty blockers and cross-sex hormones.** (NAPP, 18 March 2022)

c. **In April 2023, the Royal College of Psychiatrists (RCPsych) said it planned to review** its Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (2013) that **states the World Professional Association for Transgender Health standards of care, version 2011, "have informed these UK standards of care". On 22 April 2024, the RCPsych published a generally favourable response to the Cass Report. (RCPsych, April 2024)**

d. **On April 5, 2024, the UK Council for Psychotherapy withdrew its signature from the Memorandum of Understanding and its membership from the Coalition Against Conversion Therapy, citing concerns after obtaining confirmation that the MoU applies to children** and exploring a new coalition with "a specific focus on being psychotherapeutically informed and led….with new evidence being incorporated as it emerges." (UKCP, 5 April 2024)

e. **Finland's national "Recommendation" regarding gender care (Council for Choices, COHERE, 2020) says psychiatric disorders and developmental difficulties may predispose to gender dysphoria, and medical gender**

affirmation does not treat them. It says, "In adolescents, psychiatric disorder and developmental difficulties may predispose a young person to the onset of gender dysphoria." It also says, "Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." (chapter 6) Therefore it says, "The first-line intervention for gender variance during childhood and adolescent years is psychosocial support and, as necessary, gender-exploratory therapy and treatment for comorbid psychiatric disorders." (chapter 7)

f. **Sweden's National Board of Health and Welfare (NBHW) now recommends psychiatric care for adolescent gender incongruence.** "For adolescents with gender incongruence, the NBHW deems that the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases." (NBHW, 2 Feb. 2022. p. 2) An English summary of the recommendations says that therefore, "psychiatric care and gender-exploratory psychotherapy will be offered instead." (SEGM, 27 Feb. 2022, p. 2)

g. The Norwegian Healthcare Investigation Board has recommended that the government of Norway move away from medical gender interventions (Block, 6 July 2023; SEGM, 9 March 2023). Reportedly, also, the medical directors of Norway's four health regions have determined that puberty blockers and cross-sex hormones are experimental for minors and should be allowed only within a clinical experimental context. (Lane, 2024) We are watching for how the government of Norway will heed these recommendations.

h. Also, physicians in Denmark have published a statement that the guidelines in Denmark for treating gender dysphoria are undergoing revision to move away from medical intervention toward "noninvasive resolution of gender dysphoria" (SEGM, 17 August 2023; Løhde, 2023). We will watch over time to see what changes may be made.

i. The New Zealand Ministry of Health has published research briefs for research on puberty blockers. It has concluded, "Overall, the evidence brief found significant limitations in the quality of evidence for either the benefits or risks (or lack thereof) of the use of puberty blockers. This means there is insufficient basis to say that puberty blockers are safe or reversible (or not) for use as an intervention for gender dysphoria in adolescents. The brief warns, "Noting that the Government has signalled an intent to consider regulating puberty blocker prescribing in gender-affirming care, clinicians should exercise caution in prescribing." At this time, "Health New Zealand is currently developing an updated set of guidance to support clinicians providing gender-affirming care, including the use of puberty blockers." (New Zealand Government Ministry of Health, November 2024, pp. 4, 6)

j. **United States: At least half of the 50 states have laws prohibiting gender affirmative interventions. (ACPeds, May 2025, States That Protect) The state of Florida commissioned a systematic review and now prohibits using puberty blockers, cross-sex hormones, or surgeries to treat gender dysphoria in minors and recommends, "Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."** (Florida Department of Health, 20 April 2022) **For both adults and minors**, Florida Medicaid (government funded health care for low-income people) will not pay for gender transition. (Division of Florida Medicaid, 2022)

101. Some professional organisations have acknowledged there are pathological psychiatric causes for gender incongruence for some people, even if these organisations generally have taken a position that gender incongruence is normal.

a. **The American Psychiatric Association Task Force on the Treatment of Gender Identity Disorder** (2012) noted gender dysphoric adolescents should be "screened for trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent's decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition". (Byne et al., 2012, p. 764)

b. **The World Professional Association for Transgender Health,** in its earlier Standards of Care, under the former Version 7, said gender dysphoria may be *"*secondary to or better accounted for by other diagnoses*"* (Coleman et al., 2012, p. 180). Version 8 says transgender and gender diverse identified adolescents "show high rates of autism spectrum disorder/characteristics", and other "neurodevelopmental presentations and/or mental health challenges may also be present" such as attention deficit hyperactivity disorder (ADHD), intellectual disability, and psychotic disorders. (Coleman et al., 2022, p. S62, S71)

c. **The early (2012) British Psychological Society Guideline** said, "In some cases the reported desire to change sex may be symptomatic of a psychiatric condition for example psychosis, schizophrenia or a transient obsession such as may occur with Asperger's syndrome…." (p. 26) The 2019 Guideline says regarding people with "GSRD identity" (gender, sexuality, and relationship diversity") that "behaviours and feelings may be evidence of a mental health condition or acquired brain injury for example", but it says this occurs "in extremely rare instances". (BPS, 2019, p. 6) Research presented below shows the mental health conditions are common, however, not rare.

d. **The American Psychological Association's *APA Handbook of Sexuality and Psychology*** gave consideration to research suggesting there may be pathological psychodynamic or family causes. "Research on the influence of family of origin dynamics has found some support for separation anxiety

among gender-nonconforming boys and psychopathology among mothers….” (Bockting, 2014, in *APA Handbook*, vol. 1, chapter 24, p. 743; see Bradley & Zucker, 1997).

102. Research internationally has found an association between gender dysphoria and high rates of psychiatric conditions in adolescents and adults. This association is widely accepted and not controversial. Associated psychiatric conditions have included psychiatric disorders, neurodevelopmental disabilities such as autism, self-harming behaviour, and suicidality. Prevalence rates of these conditions have ranged from about 50% to 89%, especially in studies that probably provide the most reliable estimates (examples: 50% to 80% lifetime prevalence in adults: Zucker et al., 2016, p. 227; 89% prevalence in gender clinic adolescents: Kozlowska, Chudleigh, et al., 2021) These high rates have been found in 10 European countries including the United Kingdom and in the United States, Canada, Australia, New Zealand, Iran, Japan, and South Korea. The systematic review of research through 2022 conducted at York University for the Cass report for NHS-England concluded, “Adolescents presenting at specialist centres for support / treatment in relation to GD are highly likely to have other MH [mental health] problems (including neurodivergence [example, autism spectrum disorder]). (Thompson et al., 2024, p. 41)

103. Many studies found high rates of psychiatric conditions for children, adolescents, and adults as follows:

a. International: “Children and adolescents [under 18] show higher than expected levels of ASC [autism spectrum condition], ADHD [attention disorder hyperactivity disorder], anxiety, depression, eating disorders, suicidality, self-harm and adverse childhood experiences.” Reported in the systematic research review conducted in 2022 of 143 studies from 131 articles across 17 countries for the Cass Review. (Taylor et al., 2024, Characteristics of children and adolescents, p. 6)
b. U.K.: 87% in a small representative population cohort (Boyd et al., 2022, calculated from Table 3 on p. 10 from 13% “none of the above diagnoses”)
c. U.K.: 72% in 175 consecutive NHS adult (ages 19 to 89) gender services cohort (Hall et al., 2021, p. 9)
d. London: All new referrals to the Gender Identity Development Service (GIDS) in London over 1 year, ages 0 to 18: many often present with a wide range and number of associated difficulties. (Holt, Skagerberg, & Dunsford, 2016, abstract, p. 110)
e. Finland: 75% of adolescent gender clinic applicants had psychiatric treatment for disorders in their lifetime other than gender-related lifetime (Kaltiala-Heino et al., 2015, p. 5)
f. Norway: 75% of adolescent gender clinic patients had mental illness (Lane, 29 Feb. 2024, p. 3)
g. The Netherlands, Belgium, Germany, and Norway: adult gender clinic applicants nearly 70% (Heylens et al., 2014, abstract)
h. Spain: adult cohort of sex surgery applicants 56% male to females and 70% female to males (Gomez-Gil et al., 2009, p. 387)

i. Italy: 52% Axis II disorders in sex surgery patients (but study did not assess prevalence of Axis I disorders and excluded patients with “Current major psychiatric disorders” (Madeddu et al., 2009, p. 263)
j. Italy: 50% (limited assessment) personality disorders in volunteer recruits from adult gender clinic only who had no “major” psychiatric disorders (Anazani et al., 2020)
k. Switzerland: 71% sex surgery patients had Axis I disorders and 42% had Axis II disorders (Hepp et al., 2005, abstract)
l. Sweden: “very high” for all ages in national gender services (NBHW, 2020, under “Suicide Mortality”)
m. Sweden: “Trans-sexual individuals had been hospitalized for psychiatric morbidity other than gender identity disorder prior to sex reassignment about four times more often than controls [matched peers from the general population].” (Dhejne et al., 2011)
n. U.S.: 32-34% children and 71-75% adolescents had lifetime psychiatric conditions *prior* to evidence of gender nonconformity in a Kaiser-Permanente health maintenance organisation in 2 U.S. states: (Becerra-Culqui, et al., 2018, Tables 2 and 3)
o. U.S.: 89% for transgender and gender diverse adolescents compared to 50% in their siblings who were gender congruent in an entire cohort of youths in all U.S. military families domestic and abroad over 8 years. (Hisle-Gorman et al., 2021, Table 2 on p. 1447)
p. U.S.: 58% psychiatric diagnoses on average for all ages with transgender diagnosis in 26 health care systems in 50 states: (Wanta et al., 2019)
q. U.S.: 78% college students (Lipson et al., 2019, abstract)
r. U.S.: 77% of adults with gender dysphoria at discharge from a hospital encounter (Hanna et al., 2019, abstract)
s. U.S.: 59% of adolescent students reporting “long term mental health problems” (Rider et al., 2018, Table 3 on p. 4)
t. U.S.: 63% (62.5%) adolescents and young adults according to parent reports (Littman, 2018 and correction 2019, p. 1)
u. U.S.: 43% of the first 70 transgender youth presenting for hormone treatment in the first US interdisciplinary paediatric gender clinic had psychiatric histories (Edwards-Leeper et al., 2017, p. 375)
v. Canada: 60% of adolescents had “prior” disorders in a gender clinic (Bechard et al., 2017, p. 681 and Table 1)
w. Toronto, Ontario, Canada and Amsterdam, The Netherlands: 40% (39.3%) to 78% (77.5%) of gender clinic adolescents (de Vries et al., 2016, Table 3 on p. 584)
x. Toronto, Canada: 26% of children ages 3-5 years, 62% of older children ages 6-23, and Utrecht, The Netherlands: 44% children aged 3-5 years, 62% older children ages 6-22 years (Cohen-Kettenis et al., 2003, pp. 46-47)
y. Australia: 89% total, including 14% autism, of gender clinic children ages 8-15 (Kozlowska, Chudleigh, et al., 2023, abstract and companion study Kozlowska, McClure, et al., 2021, Table 2 on p. 79, total calculated from 11.4% “no comorbid mental health condition/symptoms)

z. Australia: at least 75% according to adolescents, young adults, and parents/guardians online survey (Strauss et al., 2017, Executive Summary)
aa. Australia: adults depression 56% (55.7%), high autism spectrum disorder, and more mental disorders higher than age-matched peers in general population (Cheung et al., 2018, abstract)
bb. New Zealand: 71% "high or very high psychological distress" in adolescents and adults online survey (Veale, et al., 2019, p. iv)
cc. Japan: gender clinic adults, reports only suicidality 76% (76.1%) males and 72% (71.9%) females but virtually denied any psychiatric disorders whatsoever, eliminated people from the study who had disorders, and did not use a structured interview, hence may be less reliable (Hoshiai et al., 2010, abstract);
dd. English peer-reviewed articles: The prevalence of autism spectrum disorder (ASD) in gender dysphoria/incongruence (GD/GI) individuals was 11 times higher than the 1% in the general population. (Kallitsounaki & Williams, 2023, p. 3111)
ee. All English peer-reviewed articles: "The few studies employing diagnostic criteria for ASD suggest a prevalence of 6–26% in transgender populations, higher than the general population, but no different from individuals attending psychiatry clinics." (Thrower et al., 2020, abstract)

104. Most studies that show a high correlation between psychiatric conditions and gender discordance do not tell us which came first. Some of them, however, do, and all of which I am aware show that high rates of psychiatric disorders and adverse conditions come first. This finding means potentially treatable psychiatric conditions (psychiatric disorders, neurodevelopmental disabilities such as autism, self-injuring behaviour, suicidality, and trauma from adverse childhood experiences) may *predispose to or be causal for* gender discordance.

105. The largest rigorous study, conducted in the United States, found that about one third of gender incongruent children and about three-fourths of gender incongruent adolescents had lifetime psychiatric conditions that *pre-existed* first medical record evidence of gender incongruence. (Becerra-Culqui et al., 2018)

a. **Speaking of this study, the systematic research review on the mental health of gender dysphoric adolescents conducted at York University through November 2022 for the Cass review for NHS-England said it ranked in the "highest quality" category, it was the "only large population study" in the review (Thompson et al., 2024, p. 18), and the researchers "were able to show that there was a high degree of MH [mental health] problems on records prior to first GD [gender dysphoria]-related presentation" (p. 17).**

b. **The research design:** (Becerra-Culqui et al., 2018)

i. This 8-year study looked at the *complete* electronic medical records of an *entire cohort* of 8.8 million members enrolled in the Kaiser-Permanente multi-state integrated health care insurance system for 2

U.S. states (at its sites in Georgia, northern California, and southern California) from 2006 to 2014.

ii. Thus, individuals with gender incongruence in this study were not limited to individuals who applied for or had been approved for transgender treatment services or who were in required pre-operative therapy for sex surgery. Also, the study did not rely on self-reports of recruits from either change-allowing or from discordant-identity-affirming communities who may have had an interest in presenting themselves in particular ways.

iii. Researchers identified 1,333 (588 male-to-female and 745 female-to-male, 251 children and 1082 adolescents) gender nonconforming children (ages 3 to 9) and adolescents (ages 10 to 17). Each gender incongruent child and adolescent was matched with 10 gender congruent peers of each sex (10 males and 10 females) for the purpose of making comparisons in rates of psychiatric disorder prevalence.

c. **The researchers found:**

i. *Among children ages 3-9, lifetime* rates of having 1 or more psychiatric disorders *before* first medical record evidence of gender *incongruence* were 34% for biological girls and 32% for biological boys. By contrast, comparable lifetime rates of having 1 or more psychiatric disorders for gender *congruent* peers were 3% for boys and 5% for girls.

ii. Among children ages 3-9 during the *6 months before* first medical evidence of gender incongruence, rates of having 1 or more psychiatric disorders were 29% for both biological boys and biological girls. By contrast, comparable rates of having 1 or more psychiatric disorders for gender *congruent* peers during the simultaneous 6 months were 3% for boys and 5% for girls.

iii. Among children ages 3-9, psychiatric disorders children manifested *before* first medical record evidence of gender incongruence were: anxiety disorders, attention deficit disorders, autism spectrum disorders, conduct and/or disruptive disorders, depressive disorders, and eating disorders.

iv. Among adolescents ages 10-17, *lifetime* rates of having 1 or more psychiatric disorders *before* first medical record evidence of gender *incongruence* were 71% for biological boys and 75% for biological girls. Thus, notably, gender incongruent adolescents *usually* had psychiatric conditions *before* first evidence of gender incongruence. By contrast, comparable lifetime rates of having 1 or more psychiatric disorders for gender *congruent* peers were 3% for boys and 4% for girls.

v. Among adolescents ages 10-17 during the *6 months before* first medical record evidence of gender incongruence, rates of having 1 or more psychiatric disorders were 59% for biological boys and 66% for biological girls. By contrast, rates of having 1 or more psychiatric disorders during the simultaneous 6 months for gender *congruent* peers were 7% to 9% for boys and girls.

vi. Among adolescents ages 10-17, psychiatric disorders they manifested in their lifetime *before* first medical record evidence of gender incongruence were: anxiety disorders, attention deficit disorders, autism spectrum disorders, bipolar disorders, conduct and/or disruptive disorders, depressive disorders, eating disorders, psychoses, personality disorders, schizophrenia spectrum disorders, self-inflicted injuries, substance use disorders, suicidal ideation.

vii. Autism spectrum disorder lifetime prevalence rates for biological boys ages 3 to 9 was 5%, which was 2 to 4 times higher than for gender congruent peers. No biological girls ages 3 to 9 (either gender incongruent or congruent) were diagnosed with autism spectrum disorder. Among adolescents ages 10 to 17, lifetime autism spectrum disorder prevalence rates were 7% for gender incongruent biological boys and 4% for gender incongruent biological girls, which were overall 2 to 261 times higher than for matched gender congruent peers. (Tables 2 and 3)

viii. **Note that suicidal ideation was not a focus of research interest or study in children ages 3 to 9. Among gender incongruent adolescents, 8% of biological boys and 10% of biological girls experienced suicidal ideation in their lifetime *before* first medical record evidence of gender incongruence.** These **lifetime** rates of suicidal ideation in gender incongruent adolescents were 11 to 110 times higher than for gender congruent peers. In the **6 months** *before* first medical evidence of gender incongruence, 7% of adolescent males and 5% of adolescent females experienced suicidal ideation, rates that, while they were clearly a minority of gender incongruent adolescents and not nearly as high the public may be led to believe, were still dramatically 25 to 55 times higher than for adolescent peers who identified with their sex. (Tables 2 and 3)

ix. This finding on suicidality prevalence is consistent with research in the United Kingdom, Canada, and the Netherlands that found suicidality rates (thoughts, attempts) among 2,771 adolescents in gender clinics were roughly similar to rates for adolescents in psychiatric treatment for other mental health concerns but were substantially higher than for adolescents not in psychiatric treatment. Suicidality was consistently "strongly associated with degree of general behavioral and emotional problems." (de Graaf et al., 2020)

x. **As previously quoted in full in my report, the Cass review reported** that suicides in transgender identified people "**continue to be above the national average", and "evidence…suggests that these deaths are related to…complex psychosocial factors and to mental illness."** (Cass, April 2024, 16.22 on p. 195, bold added)

xi. **Importantly, research has found that psychiatric disorders precede 90% of completed suicides worldwide** (Cavanagh et al., 2003)**. In Sweden, psychiatric disorders preceded suicidality in gender dysphoric individuals according to the National Board of Health national register**. (NBHW, 2020; unofficial English translation is unpublished.)

xii. Compared to gender congruent peers, gender incongruent adolescents ages 10 to 17 had the following higher rates of distress during the **6 months *before*** first medical record evidence of gender-sex discordance: (Becerra-Culqui et al., 2018, Table 3)

1. Depression was up to 23 to 24 times higher.
2. Suicidal ideation was up to 45 to 54 times higher.
3. Self-inflicted injuries were up to 70 to 144 times higher.

xiii. Rates that are only 2 times higher are considered notable.

d. **First electronic medical record evidence of gender incongruence,** even though medical records were kept in real time, may not perfectly tell us when gender incongruence began and whether psychiatric diagnoses or suicidality invariably or usually preceded gender incongruence. It would certainly be difficult to make a case from this study, however, that a different order predominates, that gender incongruent identity occurs first in normal children or adolescents, then change exploratory therapy occurs, and then mental health disparities and suicidality develop. The next study I will review, by Kaltiala-Heino and colleagues (2015) in Finland, used different methods and came to similar findings to the Kaiser-Permanente study in the U.S. It included in its methods in-person interviews administered by a multidisciplinary team to adolescents seeking sex reassignment services and their parents/guardians. It found that similar rates of severe psychiatric disorders commonly pre-existed thoughts about gender and were rarely secondary to gender dysphoria.

106. Psychiatric disorders and suicidality that *precede* gender nonconformity cannot be caused by change-allowing therapy that comes *after* gender nonconformity. But psychiatric disorders, suicidal thoughts, and their underlying causes such as trauma could lead to rejecting one's inborn sex and identifying as a different sex.

107. **Research evidence in Finland suggests not only severe psychiatric conditions, but also severe bullying, precede and therefore may be causal for adolescent onset of gender dysphoria, suicidality, and seeking sexual reassignment services. (Kaltiala-Heino, et al., 2015) The systematic research review conducted at York University for the Cass review commissioned by NHS-England ranked this study among the very highest within the "highest quality" category.** (Thompson et al., 2022) It looked at a complete cohort of 47 adolescent applicants for "sex reassignment" services at one of the two centres for this service in Finland from 2011 to 2013 using "a structured quantitative retrospective chart review and qualitative analysis of case files". Adolescent assessments consisted of "structured and free format assessments and interviews with an adolescent psychiatrist, a psychiatric nurse, a social worker and a psychologist. The adolescent and her/his parents/guardians are seen together and separately by all the multi-disciplinary team members." (Kaltiala-Heino et al., 2015, abstract, p. 2) The researchers found the following. (Kaltiala-Heino et al., 2015)

a. **"Severe psychopathology preceding onset of gender dysphoria was common**. Autism spectrum problems were very common." (Abstract) "Seventy-five per cent of the applicants (35/47) [35 out of 47 sex reassignment applicants] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria when they sought referral." (p. 5) **"The recorded comorbid disorders were thus severe and could seldom be considered secondary to gender dysphoria."** (p. 6)

b. **Further, 57% had been significantly bullied at school. Among these, 92% had been severely bullied "before they came to think about their gender identity"** (73% before, 19% *both before* and after, 8% only after). The bullying was "particularly intensive, vicious, long-term, and traumatizing." (p. 6) About three-quarters, 73%, were bullied for reasons unrelated to "gender presentation or gender or sexual identity". (pp. 4, 6) In nearly half the cohort (49%, 23 of the 47 adolescents), persistent experiences of bullying *before* first thoughts of gender incongruence were found to be associated with peer isolation, "social anxiety, depression, most often with self-harm and suicidal preoccupation if not attempts." As applicants for gender services, these adolescents had "very high expectations that SR [sex reassignment] would solve their problems in social, academic, occupational and mental health domains." ("e group" on Table 2, also pp. 4, 6)

c. **The researchers appear to suggest severe psychiatric disorders, *general* identity confusion, neurodevelopmental disabilities, and/or bullying may have been causal for gender dysphoria or transgender identity, especially for the 49% who were persistently bullied** ("group e" on Table 2, p. 6) **and the 26% diagnosed with autism spectrum disorder.** (p. 7) (These groups may overlap.) One may note that 87% of the adolescent gender clinic patients were females. This study from Finland taken alone does not have a large enough number of participants to *prove* cause, but, taken together with the U.S. study above (Becerra-Culqui et al., 2018) and other studies (Bechard et al. 2017; Kozlowska, Chudleigh, et al., 2021 taken together with its companion study

Kozlowska, McClure, et al., 2021; Thrower et al., 2020; Kallitsounaki & Williams, 2023), there is evidence that psychiatric disorders and adverse childhood experiences are associatively and potentially causally linked to gender incongruence. As previously cited, Finland's Recommendation in 2020 (Council for Choices, 2020) states, "In adolescents, psychiatric disorders and developmental difficulties may predispose a young person to the onset of gender dysphoria" (chapter 7), and the first line treatment to reduce gender dysphoria includes treatment to reduce psychiatric disorders.

108. In Canada, researchers found that 60% of 50 consecutive adolescents referred to a specialised gender identity service had "a prior diagnosis" other than "gender identity disorder", and previous therapists had ignored these with harmful results. (Bechard, et al., 2017, p. 681, Table 1 on p. 682. "Gender identity disorder" was the diagnosis given before "gender dysphoria" became a diagnosis currently used.) The researchers gave case examples concerningly illustrating that previous evaluations of these adolescents had ignored significant histories of disorders that existed *prior to onset* of gender identity disorder. (pp. 682, 684-685)

109. In Australia, onset of gender dysphoria in children and adolescents (ages 8 to 15) was seen to have arisen in the developmental context of exceedingly high rates of psychiatric conditions and adverse childhood experiences (ACEs), according to the developmental stories reported by the children and families in a 5-year study of an entire gender clinic cohort. (Kozlowska, McClure et al., 2021). Adverse childhood experiences are generally believed to be associated with and potentially causal for psychiatric disorders. The gender clinic staff reported the 79 children and adolescents (33 biological boys and 46 biological girls) in their gender clinic experienced the following in their developmental histories. (Kozlowska, McClure et al., 2021)

a. **89% Psychiatric disorders or conditions (including 14% autism).**

b. **98% Adverse childhood experiences (ACEs), on average 5, usually in the family:**

   i. Family conflict
   ii. Loss by separation as from a parent or grandparent
   iii. Mother mental illness
   iv. Father mental illness
   v. Bullying
   vi. Maltreatment—almost two-thirds of the children:
   vii. Exposure to domestic violence
   viii. Emotional abuse
   ix. Physical abuse
   x. Sexual abuse

c. **Families did not think they were troubled. They saw gender dysphoria as an isolated problem. An affirmative approach misses that the entire family often is in crisis, and it is not being addressed.**

i. Researchers said, “Despite the clinicians’ perspective that families presenting to the Gender Service were typically in substantial distress and struggled in many domains of family function—as evidenced by their stories of conflict, relationship breakdown, parental mental illness, and maltreatment,….families tended to medicalise the child’s distress….The motivation to engage in individual or family work to explore the broad range of difficulties and psychological, family, or loss/trauma issues contributing to the clinical picture was generally low.” (Kozlowska, McClure et al., 2021, pp. 85-86)

ii. Evidence in other research that siblings of a gender dysphoric adolescent also have high rates of psychiatric disorders also suggests the family is troubled. This finding comes from a large U.S. military registry study discussed elsewhere in this report. (Hisle et al., 2021) Rates of psychiatric diagnoses were 89% for gender dysphoric adolescents and 50% for their siblings—also high. Rates of psychiatric pharmaceutical use were 75% for gender dysphoric adolescents overall, 89% for gender dysphoric adolescents on gender pharmaceuticals, and 38% for siblings. Use of psychiatric medications suggests mental health disorders were significant or serious.

iii. Given such a context, a parent whose support prioritises a thorough multi-disciplinary evaluation and psychotherapy over medical gender transition may increase parent-adolescent conflict if not family conflict generally but be acting in support of the child’s best interests. A parent who supports an adolescent in prioritising a medical transition path that an adolescent may want may feel comforting and less stressful to the adolescent and the family but not address the adolescent’s underlying needs. Parental support for discordant-gender-affirming treatment may result in reinforcement of gender incongruence and prevent natural desistance or much needed psychosocial treatment. (Zucker, 2018; Florida Department of Health, 2022)

d. **The gender clinic staff reported they felt unsafe as they attempted to evaluate and treat gender dysphoria according to a holistic, biopsychosocial model in the context of family pressure and media promotion of a strictly affirmative treatment model.** (Kozlowska, McClure et al., 2021, p. 84)

e. **The researchers also experienced pressure to restrict themselves to the affirmative model in their research**. The researchers in this study said, (Kozlowska, McClure et al., 2021, p. 88)

> The fifth challenge pertained to the issue of research. In this context, we had set up research as part of the clinic’s routine activity, enabling us to contribute to the evidence base regarding children who present with gender dysphoria. In the process of writing up data from our clinic,

> we became aware that the process of knowledge development— ours and that of other researchers—was at risk of being thwarted by ideology…. In 2019, in response to this issue, the Society for Evidence Based Gender Medicine was founded "'to promote safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria' (Society for Evidence Based Gender Medicine, 2020) (https://www.segm.org)."

f. **The researchers noted they were not unique in their experience of fear-inducing pressure to follow an affirmative medical path rather than a comprehensive, holistic one that treats underlying primary mental health problems. They quoted anecdotal evidence that professionals worked under similar pressure at the Tavistock clinic. (Kozlowska, McClure et al., 2021, pp. 89-90) As I discuss elsewhere in my report, Dr. Hillary Cass documented that some professionals in MoU signatory organisations similarly told her they felt afraid under pressure from the MoU and threats of a legislative ban and were not accepting referrals to treat gender dysphoric children at all, contributing to the overload at the Tavistock and its closure and to difficulty recruiting therapists for the new NHS-England model of treatment. (Cass, 2022, p. 48)**

g. **This research article itself did not specifically address direction of causation between the adverse associations they found with gender dysphoria and development of gender dysphoria. Researchers from the same clinic, however, published a companion study I present next that did take up this discussion with considerable thoughtfulness.**

h. **A companion study from this Australian gender clinic published the same year assessed gender dysphoric children as having poor quality attachment patterns and high rates of unresolved trauma or loss accompanying their many adverse childhood experiences. The researchers provided a very thoughtful discussion on the question of direction of causality between these findings and the children's gender dysphoria. Their discussion addressed the question, what leads to what?** (Kozlowska, Chudleigh et al., 2021, an expanded discussion following Kozlowska, McClure et al., 2021)

i. **In the companion study, the researchers began by assessing the attachment type and degree of unresolved trauma or attachment loss among gender dysphoric children in their clinic compared to age and sex matched children with mixed psychiatric disorders and children from the community (a non-clinical group). They found no difference in quality of attachment between the gender dysphoric group and the psychiatric disorders group. Both of these groups were mostly classified into poor quality attachment patterns that placed them at high risk for psychopathology later in life** and high likelihood of having suffered unresolved trauma or loss, in contrast to the non-clinical group that was primarily classified as having normative attachment types and a low rate of unresolved trauma or loss. (Kozlowsa, Chudleigh et al.,

2021, Abstract) The quality of a child's or adolescent's attachment is how secure a child feels that the caretaker is available and responsive to the child's needs. Attachment is a sense of lasting psychological connectedness between the individual child and the caretaker which over a lifetime of experiences generalises to a sense of connectedness between the individual and others.

j. **The global level of functioning for the gender dysphoric children was impaired.** Lower socioeconomic class, not living in a traditional family unit of biological mother and father, maltreatment (physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence) increased the likelihood of a high-risk attachment type. (Abstract) Among non-clinical children from the community, 75% lived with their biological mother and father, while among gender dysphoric children, 35% lived with their biological mother and father. (p. 10)

k. The researchers were interested in understanding broadly "the processes—biological, psychological, relational, and cultural—that have come together to shape the child's developmental pathway." (p. 2)

l. They explain that the broader literature shows associations between such factors as they found in their gender clinic and the health and well-being in children and adolescents generally, but

> the causal pathways are complex and non-linear, and the processes and mechanisms by which adversity affects brain and body development, as well as the well-being of children and adolescents, are still in the process of being elucidated....
> Nonetheless, from the perspective of attachment theory and systems thinking, **the problems of troubled children, including those with gender dysphoria, emerge from a complex and ongoing interplay between genetic factors, experience (including ACEs [adverse childhood experiences] and the quality of the child's attachment relationships), the biological embedding of experience via epigenetic and neuroplastic mechanisms in the body and brain, and sociopolitical and cultural factors (including socioeconomic disadvantage**....(p. 15)

m. As previously explained in this report, epigenetics refers to processes by which genes are turned off or on. Life experiences may modify a person's epigenetics, affecting how much genes are expressed. Neuroplastic mechanisms refer to the reality that life experiences modify a person's brain. This interplay between biology, experience, and the child's attachment relationships, the researchers continue,

> occurs across time in an ongoing fashion beginning with the previous generation(s), across the child's lifespan—from conception to death—and into subsequent generations. (p. 15)

n. The researchers have again here referred to epigenetics. After genes have been affected (turned more off or more on), they may be passed down to the next generation in affected form. Children who have gender dysphoria may have been so impacted by their parents' genes and may in turn impact the genes of their own children.

n. **This broad perspective contrasts with a viewpoint that gender dysphoria just exists, or people are born with it, and psychological problems of gender dysphoric children and adolescents are just due to others not affirming them, or the children's gender dysphoria causes the adverse childhood experiences to be inflicted on them**. Such views do not evidence curiosity to inquire into the complexities in which gender dysphoria arose. Further, **it is highly unlikely that a child's or adolescent's gender dysphoria could cause all these adverse experiences in all these children and adolescents**—for example could cause low socioeconomic status, not living with both biological parents, parent mental illness, witnessing domestic violence. The responses of family members and peers to gender dysphoria, after it is manifest, may influence its continued trajectory and psychological stress, but, as research presented elsewhere in this report found, family and peer relationships account for the psychological functioning of a gender dysphoric child, regardless of whether the family is discordant-gender-identity-affirmative or not.

o. **The MoU** uncritically accepts affirming gender discordance, harmfully discourages consideration of and inquiry into potential treatable causes, and requires a viewpoint that there should be no preference between gender discordance or contentedness with one's body. **The preferred MoU viewpoint appears to be that gender discordance just is and there is nothing more to see here. The MoU position is inadequate for clinical practice and research and serves as a harmful, restraining force.**

p. **Clinicians should be able to perform comprehensive evaluations into potential causes of gender dysphoria and treat them with the potential outcome of gender dysphoric patients becoming more comfortable and confident in their sex. This is what professional therapists do who are open to a client's goal of gender dysphoria resolution as an outcome of evaluation and treatment. Such an approach should not be characterised as "conversion therapy" or be forbidden.**

110. An *adult* gender clinic in Italy (Giovanardi et al., 2018) found similar attachment problems in gender dysphoric patients as did the *child* gender clinic in Australia (Kozlowska, Chudleigh, et al., 2021). A study of transgender adults recruited from university hospital gender services in Rome and Naples, Italy found gender dysphoric adults evidenced insecure attachment to their parents to a degree that was "strongly and significantly different" from adults who identify with their sex but no different from adults who had clinical diagnoses other than gender dysphoria. (Giovanardi et al., 2018, p. 5) **Secure or insecure parent attachments are**

observed to form during the first year of life, and they therefore pre-exist a child's development of a gender identity which emerges from about 2 ½ to 3 years of age, though experiences may continue to impact attachment style throughout life. Researchers assessed attachment style using the well-recognised Adult Attachment Interview. Biological men who identify as women, in comparison with biological men who identify as men, "(1) were more neglected by both parents; (2) had more involving, rejecting and physically and psychologically abusive fathers; and (3) suffered more frequently from an early loss of the father." (An "involving" parent is not necessarily involved in a positive way. Involvement contrasts with neglect but may be smothering, dominating, or abusive in nature.) These predominantly father problems were associated with biological men not identifying as men. On the other hand, biological women who identified as men, compared to biological women who identified as women, "(1) were more often victims of intensive rejection, neglect and early separation from fathers; (2) had more psychologically abusive mothers; and (3) prematurely experienced more losses of close relatives and friends." For biological women who disidentified with their sex, "the main psychologically abusive figure…was the mother and not the father." (p. 9) These predominantly mother problems were associated with biological women not identifying as women.

111. **As previously reported, many children in GIDS had experienced absence or loss of at least one parent or abuse. "5.50** A review of the first 124 cases seen by GIDS (Di Ceglie et al., 2002) found that just over a quarter of all referrals had spent some time in care and nearly half of all referrals had experienced living with only one parent. It showed that 42% of the children covered by the audit experienced the loss of one or both parents, mainly through separation; 38% had family physical health problems; and 38% had family mental health problems. Physical abuse was documented in 15% of cases." (p. 94)

112. **Several studies internationally have found gender dysphoric children and adolescents have the same higher prevalence of mental health problems as children and adolescents referred for other diagnoses, regardless of whether the study used parent report, teacher report, or self-report. Poor peer relations were the strongest predictor of mental health problems.** (Research review: de Vries, 2016, see p. 280; Thrower et al., 2020) These studies cannot tell us the direction of cause. It may be that troubled children have difficulties with relationship skills that in turn lead to being bullied, or the reverse could be true in that being bullied may lead to relationship challenges and mental health problems, or family dysfunction and/or other adverse childhood experiences may lead to both mental health problems and poor peer relationship skills that in turn may lead to being bullied.

113. **The mental health problems of gender dysphoric young people are more complex than can be understood simply by discrimination**. In Finland, the large (139,829 8th and 9th grade students) School Health Promotion Study of the National Institute for Health and Welfare found, "Both experience of being bullied and perpetrating bullying were more commonly reported by transgender youth than by cisgender youth." It explained that "involvement in bullying as a bully, victim or both has been associated with a range of negative health outcomes." (Heino, Ellonen, &

Kalatiala, 2021, abstract) A simple explanation of societal discrimination fails to consider these complexities and may neglect thoroughly evaluating for them and providing appropriate treatment with regard to them.

114. Many additional studies have found that incongruent gender identity, like same-sex sexuality, is associated with high rates of history for adverse childhood experiences. (Baams, 2018; Schneeberger et al., 2014, systematic review of 73 studies).

115. Incongruent gender identity develops when a child of sensitive or vulnerable temperament, in the context of troubled families, "comes to perceive the opposite sex as being more valued or secure." The child's solution is a fantasied opposite-sex self and cross-sex behaviour. The opposite-sex parent may encourage this. This is an explanation of the development of gender incongruent identity that evolved out of an early comprehensive overview of clinical and research literature, clinical experience, and research on sexuality and gender in children and adolescents by Kenneth Zucker and colleagues. The title of the overview is *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* and was definitive in its time. The lead author, Kenneth Zucker, is considered a leading international expert on gender dysphoria. (Zucker & Bradley, 1995, pp. 262-264)

116. The *APA Handbook of Sexuality and Psychology* cautions, an affirmative approach "aims to assist the environment (family, school, community) in fully accepting the gender-variant identity of the child…. **This approach runs the risk of neglecting individual problems the child might be experiencing** and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist…" (Bockting, 2014, in *APA Handbook*, vol. 1, chapter 24, p. 750; Steensma et al., 2013).

117. Young people (ages 11 to 21) commonly had mental health problems prior to parent-reported, rapid onset of gender dysphoria (ROGD) according to emerging, nonrepresentative, and controversial research. (Littman, 2020; Dias & Bailey, 2023) The young people with reported prior mental health issues were the most likely to socially or medically transition, according to surveyed parents. (Diaz & Bailey, 2023) The parents in these surveys mostly expressed progressive social values about sexuality and gender but reported concern about their child's apparently sudden change in gender identity and distress, often following mental health issues, extended focus on social media, and peers who were transitioning together. (Littman, 2018; Diaz & Bailey, 2023) Transgender activists have pressured the publishers of these peer-reviewed journal articles to retract the studies. Littman's (2019) article was peer-reviewed again and republished with minor changes. The Diaz & Bailey (2023) article was retracted but republished in another journal. Many social scientists are defending the article and protesting the retraction. (SEGM, 10 June 2023c; Bailey, 10 July 2023)

118. The following emerging research on detransitioners is, in itself, evidence for the need for therapy that explores possible pathological causes and treats these causes, hopefully before medical interventions but also after the body harm is done.

Nonrepresentative surveys and reports of people who regret medical or surgical transition and who detransition indicate many came to understand their gender dysphoria was caused by a trauma or mental disorder, and they came to embrace their inborn sex. Tragically, they reported, doctors did not evaluate them for possible pathological causes of gender dysphoria or treat these causes. (Vandenbussche, 2021; Littman, 2021; Heyer, 2019; 2011) As Finland's Recommendation says, "Although patients may experience regret, after reassignment treatments, there is no going back to the non-reassigned body and its normal functions." (COHERE, 2020, chapter 6)

a. **In one nonrepresentative survey, adults who detransitioned from medical or surgical transition said they felt their gender dysphoria was caused by psychological disorders or trauma that resolved or that they wanted therapy to resolve. Detransitioners said therapists were not trained in how to give them therapy that resolves gender dysphoria by treating underlying psychopathology or were too afraid to provide such care because of risk it might be considered "conversion therapy."** (Vandenbussche, 2021)

    i. 237 Detransitioners were recruited from social media.
    ii. **92% Females**
    iii. From Western countries
    iv. **Transitioned a little before age 18 on average**
    v. **Detransitioned after 4 years on average**, at 22 years of age on average
    vi. High rates of psychiatric diagnoses they reported:
        1. **96% had psychological issues**
        2. **54% had <u>at least 3</u> psychiatric diagnoses**
        3. 70% Depression
        4. 63% Anxiety
        5. 33% Post traumatic distress disorder
    vii. **Some reasons for detransitioning:**
        1. **70% "Realised that my gender dysphoria was related to other issues."**
        2. **62% "Health concerns"**
        3. **50% "Transition did not help with my dysphoria."**
        4. **43% "Change in political views."**
        5. **34% "Dysphoria resolved itself over time." Did anyone tell them this could happen? It would be unethical not to tell patients this.**
        6. **30% "Mental health issues related to gender dysphoria resolved." Did anyone tell them resolving mental health issues may resolve gender dysphoria? It would be unethical not to tell patients this. Does the MoU permit telling patients this?**
        7. **Write-in responses (no percentages given):**
            a. **"Realisation of being pressured to transition." Gender affirmative treatment can be coercive.**
            b. **"Realisation of the impossibility of changing sex."**
            c. **"Change in religious beliefs."**

2.

i. **Detransitioners expressed a need for therapists who will treat predisposing conditions.**

1. **"It is very hard to find a therapist who won't tell you it's 'internalized transphobia' or that dealing with dysphoria in other ways is 'conversion therapy.'"**

2. **Pressured and guaranteed results: "I was doubtful** that transition would help my dysphoria before beginning and **was assured by multiple professionals** that transition was **The Solution and proven to work for everyone** with dysphoria." **It is unethical** for affirmative professionals to pressure, to guarantee results, or **not to tell clients alternate treatment options.**

3. **"The biggest issue for me was that when I did try to get support from a therapist or psychologist on entangling the actual reasons behind my dysphoria and how to deal with it, and deal with detransitioning, nobody had any clue or any experience, so they couldn't help me. Which made me even feel more lonely, and made detransitioning so much harder mentally than transitioning was." It would be unethical not to train professionals in how to treat gender dysphoria by treating potentially causal trauma or mental health conditions. The MoU affirmative approach appears to oppose this and therefore to be unethical."**

b. **Interestingly, therapists also have been reported to be afraid to try to help people who have undesired same-sex attraction. "**I sought numerous counselling with the **NHS** and a few churches but **no one could really address it. Most were even scared to deal with it."** (Male, 35, England) (IFTCC, April 2024)

c. **In another nonrepresentative survey on gender detransitioners, the majority expressed that the gender dysphoria was caused by something specific such as a trauma or a mental health condition, but again, doctors did not evaluate or treat them for this.** (Littman, 2021, bold added)

i. 100 Detransitioners
ii. 69% Female
iii. 90% White
iv. 63% No religious affiliation
v. 93% support the rights of gay and lesbian couples to marry legally.
vi. "Nearly all participants identified as transgender or nonbinary at the start of their transition and most sought transition because they did not want to be associated with their natal sex, their bodies felt wrong

the way they were, and they believed that transition was the only option to relieve their distress."

vii. **58% expressed that the gender dysphoria was caused by something specific, such as a trauma or a mental health condition.**
viii. **"Because these conditions and events occurred before participants began to feel gender dysphoric, they cannot be considered to be secondary to gender incongruence or transphobia."**
ix. Because the information was obtained from participants reporting on their own experiences, it can be assumed that **these traumas or mental health conditions occurred before gender dysphoria onset rather than after gender dysphoria onset that might have been concealed from parents and other people.**
x. **51% "responded that they believe the process of transitioning delayed or prevented them from dealing with or being treated for trauma or a mental health condition."**
xi. Reasons for detransition included (87% chose more than one reason):
    1. **60% Becoming more comfortable identifying as their natal sex. Did anyone tell them this might happen?**
    2. 49% Having concerns about potential medical complications from transitioning
    3. **38% Coming to the conclusion that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition. Did anyone tell them these could be causes?**
    4. 23% Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual.
xii. **63% "reported that their clinicians did not evaluate whether their desire to transition was secondary to trauma or a mental health condition.**
xiii. **Most, 76%, did not inform the doctor or clinic that facilitated their transitions that they had detransitioned. "Therefore, clinic rates of detransition are likely to be underestimated** and gender transition specialists may be unaware of how many of their own patients have detransitioned, particularly for patients who are no longer under their care."

d. **These detransitioner surveys illustrate that gender dysphoria changes in adolescents and young adults and throughout the lifespan (ages 13 to 64). There is emerging evidence that up to 30% of transitioners detransitioned in their 20's, within 4 to 9 years after transition.**

i. In the Vandenbussche (2021) survey, participants detransitioned on average at nearly **23 years of age**, on average about **5 years** after starting transition. **The age range for detransition was 13 to 64 years.**
ii. In the Littman (2021) survey, the average detransition age for all respondents was **29 years**, for females was 26, and for males was 37.

iii. The first population-based study to challenge the notion that detransition is rare found that **30%** of adolescents and young adults—36% biological females and 19% biological males—had already discontinued taking "gender-affirming" hormones within the first **4 years** after starting on them. (Roberts et al., 2022)
iv. An Australian gender services prospective, naturalistic follow-up study of 79 young people over **4-9 years** duration found that the overall desistance of gender-related distress was **22%**, more than a fifth of the participants, by the time they reached about **ages 13 to 24**. Yet, from before to after gender services, the rate of psychiatric conditions persisted at 88%. (Elkadi et al., 2023, abstract, p. 19)

119. The MoU commits members of signatory organisations—the mental health professionals of the United Kingdom—to an affirmative viewpoint on discordant gender identity. There is not a professional or research consensus in support of this viewpoint to justify it. It exerts restrictions on clinicians and research that have harmed gender dysphoric individuals and have decreased access to care.

120. It would be unethical not to tell gender dysphoric people that gender dysphoria may be caused by treatable mental health conditions, that gender-affirming medicalisation is unlikely to resolve their mental health problems, and that gender dysphoria may resolve for adolescents and adults throughout the lifespan. It would further be unethical not to train practitioners to tell these things to gender dysphoric patients. It appears that providing such training may be dangerous under the MoU or under threat of a legislative therapy ban.

121. There is, in fact, evidence that mental health professionals in the U.K. are feeling fearful and restricted by their professional organisations from evaluating gender-distressed children and young people for other mental problems. This is a seriously dangerous problem. The Cass interim report commissioned by NHS England reports the following. (Cass, 2022)

a. **There is not a consensus among professionals in the NHS and the professional organisations on the causes of gender-related distress, and professionals are afraid of their organisations. The interim report says,** (Cass, 2022, p. 47, bold other than headlines added)

> **What we have heard from healthcare professionals**
> **Lack of professional consensus**
> 4.15. Clinicians and associated professionals we have spoken to have highlighted the lack of an agreed consensus on the different possible implications of gender-related distress – whether it may be an indication that the child or young person is likely to grow up to be a transgender adult and would benefit from physical intervention, or whether **it may be a manifestation of other causes of distress**. Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more

gender-affirmative approach to those who take a more cautious, **developmentally-informed approach**.

b. **As previously stated, some professionals do not feel supported by their professional bodies and out of fear of them, do not dare to apply their training to make a differential diagnosis for a gender-distressed child or young person. As a result, they were referring them straight to GIDS (Gender Identity Development Service), adding to GIDS being overwhelmed with the cases.** (Cass, 2022, p. 48)

c. **There is evidence that some professionals are harmfully assuming other mental problems are solely a result of gender dysphoria or its aftermath, leaving children and young people with these other problems undiagnosed and untreated for protracted periods of time. The interim report says,** (Cass, 2022; p. 46; similarly documented in the final report, Cass, April 2024, p. 200)

> 4.10. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria. This issue is compounded by the waiting list, which means that there can be a significant period of time without appropriate assessment, treatment or care.

d. **Serious concerns such as these have culminated in NHS closing the Tavistock.** (Andersson & Rhoden-Paul, 2022, BBS)

122. This serious issue under the MoU of directing patients to affirmative interventions and failing to diagnose and treat underlying mental health conditions may lead to body harms and regret, protracted suffering from mental health problems, and suicidal thoughts and attempts. (Bechard et al., 2017; Heyer, 2011; 2019; Littman, 2018 and correction 2019; 2021; Vandenbussche, 2021. Bold added.) **The most serious risk of misdiagnosis and neglecting to treat is completed suicides as the following research underlines.**

a. **Worldwise: 90% of people who committed suicide had unresolved mental health disorders, according to global research. The researchers' number one recommendation for preventing suicide is treating mental disorders** (Cavanagh et al., 2003, bold added).

b. US: **96%** of adolescents who experience suicidal thoughts, plans, or attempts have **at least one psychiatric disorder**, according to a nationally representative study. (Nock et al., 2013, bold added)

c. **US: "…psychopathological problems are almost always involved" in suicide**, according to the Centers for Disease Control. (O'Carroll, & Potter, 1994, bold added)

d. **Sweden (data from 2018): "[P]eople with gender dysphoria who commit suicide have a very high rate of co-occurring serious psychiatric diagnoses, which in themselves sharply increase risks of suicide. Therefore, it is not possible to ascertain to what extent gender dysphoria alone contributes to suicide, since these psychiatric diagnoses often precede suicide."** (NBHW, 2020, bold added)

e. **Sweden (1973-2003): Individuals who received national gender-affirming services over the 30 years between 1973 and 2003 completed suicide at a rate 19 times higher than matched peers from the general population who identified with their sex. Among medically transitioned people, suicide attempts were nearly 5 times higher, and hospitalisations for psychiatric disorders other than gender dysphoria were nearly 3 times higher.** (Dhejne, et al., 2011) **The explanation is complicated**. A U.S. government research review in 2016 under the Obama administration said these Swedish statistics were from the best available research at that time. (CMS 2016) The U.S. reviewers noted, "…we cannot exclude therapeutic interventions [i.e., transgender surgery] *as a cause* of the observed excess morbidity [mental illness] and mortality." (p. 62, emphasis added). **Dhejne et al. said it can be inferred that medical gender treatments are not sufficient to treat psychiatric disorders in gender dysphoric people, and treatment of co-occurring disorders is needed**. A possible confounding factor in this study is that, until 2013, Sweden required sterilisation to change legal sex. Some may have felt coerced to have sterilising sex surgery they did not want. (Nelson, 2013) The lead researcher more recently reported that the suicide rate during the later sub-period of 1989 to 2003 of the study decreased to the level of the general population. (Dhejne et al., 2016, p. 52) Even more recently, however, the National Board of Health in Sweden published that high rates of co-occurring psychiatric diagnoses were associated with suicides in gender dysphoric people. These rates were lower for those who received a confirmed diagnosis of gender dysphoria, possibly due, it said, to the diagnosis being given more often when there were fewer other psychiatric diagnoses. (NBHW, 2020) This raises a question as to whether the granting of the diagnosis and transgender treatments was more restricted in later years of the 2011 study to people who had fewer pre-existing psychiatric disorders. The 2011 study did not compare gender dysphoric diagnosed people who had versus did not have medical interventions. This comparison is needed to know whether hormone or surgery interventions improved, even if did not eliminate, risk of suicidality. The next study partially filled the gap by comparing gender diagnosed people who did or did not receive gender surgery.

f. **Sweden (2015): A large study on outcomes of transgender medical interventions found no difference between gender diagnosed people in the**

nation of Sweden who had received gender affirming surgery and matched gender-diagnosed people who had not received gender-affirming surgery during 2005 to 2015 in number of medical visits or prescriptions for depression or anxiety or hospitalisations following *suicide attempts* during 2015. The study did not assess number of *completed* suicides. The original publication of the study in 2019 erroneously reported a benefit for surgeries but not for hormones, but it used an inadequate comparison group. It used the entire population of Sweden for a comparison group, not gender diagnosed individuals who did not receive hormones or surgeries. (Branstrom & Pachankis, 2020a; 2020b; journal editor's comment on the correction: Kahlin, 2020)

g. **The Netherlands (1975 to 2007): Suicide rates were higher for transgender patients ages 16 and older who received hormone treatment for gender dysphoria over a period of 32 years at the university outpatient gender clinic in Amsterdam that treats 95% of all gender patients in the Netherlands.** Suicide rates for these patients were compared to rates for the general national population. Data collection extended over 30 years, from 1975 to 2007 or date of death, and included only patients who started hormone treatment by mid 1997 and had been followed up for at least 1 year. Average follow up time was 18 years. (Abstract, p. 636) Researchers reported, (Asscheman et al, 2011, pp. 638-639, bold added)

> **The suicide rate in MtF [male to female] was increased sixfold. Thirteen out of the seventeen (76%) had received psychiatric treatment in the past.** No suicides occurred within the first 2 years of hormone treatment, while there were six suicides after 2–5 years, seven after 5–10 years, and four after more than 10 years of cross-sex hormone treatment at a mean [average] age of 41.5 years (range 21-73 years)…. **Six MtF subjects who committed suicide (35%) had not undergone sex reassignment surgery because there had been doubts about their mental stability.**

h. **Netherlands (2013-2017): There was no difference in frequencies of suicides among patients at different levels of medical interventions during 4 years.** Patients who visited the largest national gender affirming services clinic in the Netherlands between 2013 and 2017 *completed* suicide at a rate 3 to 4 times higher than the general Dutch population. **Gender dysphoric people completed suicides about equally at every stage of transition**, and "approximately two-third [sic] of the observed suicides occurred in those who were still in active treatment (diagnostic, hormonal, or surgical phase)." These researchers did not have information about additional psychiatric disorders. (Wiepjes et al., 2020, pp. 4-5).

i. **Netherlands (1972-2017): Social stigma is not a sufficient explanation for transgender suicides according to a 45-year study**. In the Netherlands, change in cultural acceptance over nearly a half-century has made little to no

difference in suicide rates, suggesting stigma is not a sufficient explanation for suicides. During a *45-year period* from 1972 to 2017, the rate of completed suicides from year to year decreased slightly for those who received feminising treatments and did not change for those who received masculinising treatments, yet suicide rates for those who received feminising treatments continued to be higher than for those who received masculinising treatments. (Wiepjes et al., 2020, p. 5)

j. **Toronto, Canada; Amsterdam, The Netherlands; London, United Kingdom: Rates of suicidality in transgender adolescents internationally have not changed with increased acceptance over 30 years and remain strongly associated with mental health problems.** Suicidality was consistently "strongly associated with degree of general behavioural and emotional problems" in a study of 2,771 adolescents in gender clinics in Toronto, Canada, in Amsterdam, The Netherlands, and in London, United Kingdom between 1978 and 2017. While number of transgender adolescents in these clinics internationally had increased remarkably over the years, potentially suggesting increased social acceptance and decreased stigmatisation of transgender adolescents. The researchers reported, "we did not find any strong evidence that more recently assessed adolescents were any less suicidal than adolescents seen many years ago." (de Graaf et al., 2020, abstract, Discussion section)

k. **Denmark (1980-2021): Throughout the 42 years of this study, despite decreasing rates of suicides overall in Denmark, completed suicide rates for transgender-identified people remained 4 times higher than for nontransgender people. On average, first suicide attempts were about 5 years after the average age of medical transition, potentially suggesting regret for some. Overall, length of life was 11 years shorter for transgender-identified individuals compared to nontransgender individuals.** Researchers conducted a **"**Nationwide, register-based, retrospective cohort study on all 6,657,456 Danish-born individuals aged 15 years or older who lived in Denmark" from 1980 through 2021. (Abstract) Suicide *attempts* for transgender-identified people were nearly 8 times higher and *completed* suicides close to 4 times higher than for nontransgender-identified people. The median age at which transgender identity was identified was 22 years. Median age of first suicide attempt was age 27 for transgender-identified people compared to 36 for nontransgender. Median age of death from all causes was 67 for transgender-identified individuals and 78 for nontransgender. (Erlangsen et al., 2023, p. 2152) **The reduced life expectancy in this population is similar to that for people who have serious mental illness in general.** (Levine, 2018)

l. **Florida, United States: A research review found far stronger evidence for mental health issues than transphobia being a cause of suicides in gender incongruent people and found that mental health issues are causal for**

gender incongruence itself as well. One of the research reviews submitted to the Division of Florida Medicaid (Cantor, 2022) concluded,

> The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion. (p. 3)

m. **Finland (1996-2019): Registry studies have found that, for gender-diagnosed patients of all ages starting from age 3, gender "affirmative" interventions did not improve mental health and may have worsened it. The researchers concluded, "Manifold psychiatric needs persist regardless of medical GR [gender reassignment in the form of hormones, mastectomies, and/or genital surgeries]." (Kaltiala et al., 2023) At the same time, among young people who entered gender services before age 23, all-cause mortality was not higher than for the general population. Also, the suicide rate for those who proceeded to medical interventions was not different from representatives of the general population, but suicides were higher for those who did not proceed to medical interventions than for representatives of the general population. (Ruuska et al., 2024 with Sullins, 16 March 2024 comment on Ruuska et al, 2024). The Finnish finding on all-cause mortality and suicides appears to be an exception among the registry and other national cohort studies and requires explanation.** In recent years, at least, requirements in Finland's Recommendation for adolescent referral to the gender research group for hormone treatment included "absence of co-occurring symptoms requiring psychiatric treatment" and "experience of transgender identity [that] failed to resolve following a period of reflection". (Council for Choices, COHERE, 2020, Current Care; also reported in the gender services systematic review conducted by York University for the Cass report for NHS-England, Hall et al., Gender Services, 2024, pp. 3, 6, 8.) Given evidence that suicides are associated with psychiatric disorders in general (Cavanagh et al., 2003; O'Carroll, & Potter, 1994) and in gender dysphoric patients specifically (NBHW, 2020), the question is raised as to whether psychiatric preselection may account both for lower suicide rates in those who underwent medical gender interventions and for higher suicide rates in those who did not undergo these interventions, as Sullins suggested (May 2024). Additionally, Sullins suggested, fewer suicides may be due to "the presence of assessment, screening and monitoring processes that may inhibit some of the negative consequences of psychiatric morbidity, for example by ensuring better social support or medication compliance, than may be the case in other settings." A question is then also raised as to whether gender dysphoric individuals who did not obtain medical gender interventions received the same level of psychiatric surveillance and support as those who obtained medical gender interventions. Additionally, given that suicides in the Swedish study did not increase until 10 years post-medical gender interventions (Dhejne et al., 2011),

it may be that the follow-up time in the Finnish study of 6.5 years was not long enough to see endpoint outcomes.

n. **The Cass review accepts,** (Cass, April 2024, 16.22, p. 195, bold added)

> 16.22 **Tragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender affirmative treatments reduce this. Such evidence as is available suggests that these deaths are related to a range of other complex psychosocial factors and to mental illness.**

123. In sum, contrary to the apparent MoU-approved affirmative viewpoint, the best available research generally shows that gender discordance is preceded by high rates of psychiatric disorders and suicidality that persist after medical gender interventions. This research consists of multiple studies of entire cohorts of gender dysphoric individuals using objective and professional measures in multiple clinics and countries and of entire national populations over decades of follow-up using objective measures. **As a result, the following may be understood:**

124. There is research support for the view that first-line treatment for resolving gender dysphoria should include evaluating for and treating pre-existing and co-existing psychiatric disorders that may be predisposing the person to gender dysphoria and perpetuating it. This does not support an MoU-preferred viewpoint that a gender-sex concordant identity is no more preferable than a gender-sex discordant identity.

125. Rigorous research does not support the apparent viewpoint of the MoU that the best and only recourse for undesired gender discordance is acceptance that one's discordant gender identity is who one is or affirmative intervention rather than psychotherapy that explores the context in which gender discordance arose and treating potential causes with a potential outcome that gender dysphoria may resolve.

a. **There is fear that the very acknowledgement that gender dysphoria can be a symptom of treatable mental health problems and the very existence of psychotherapy for treating gender dysphoria will lead people who experience gender discordance to feel shame and lead others to mistreat them. The best way to address self-shame and mistreatment by others for mental health problems is not to deny mental health needs and their treatment but to encourage self-compassion and kindness for all. The availability of psychotherapy for those desiring help to resolve their gender dysphoria must be kept open and handled in a compassionate way. It is only ethical to do so.**

b. **Patients should be able to have the same kinds of psychotherapy to explore and resolve gender dysphoria that therapists provide for patients who want to resolve their diagnoses or disorders generally. There is no reason to call**

standard therapy "conversion therapy" when the disorder patients have a goal to resolve is gender dysphoria. This labelling discriminates against them. The MoU is forbidding ordinary therapy.

VIII. THE MoU ACCEPTS SCIENTIFICALLY UNSUPPORTED, BODY-HARMING, GENDER TREATMENTS THAT DO NOT IMPROVE MENTAL HEALTH BUT CENSORS CONSENSUAL THERAPY CONVERSATIONS

126. The MoU accepts medical interventions that sterilise, decrease ability to function sexually and to enjoy sexual pleasure, potentially remove or disfigure healthy organs, increase deaths from chronic diseases, are associated with persistence or worsening of psychiatric disorders according to several population registry studies, even as psychiatric disorders are known to be associated with increased suicide rates, and have never been shown to be more effective than psychotherapy or psychiatric medications for gender dysphoria. Yet the MoU accepts these body-altering interventions uncritically and opposes consensual psychotherapy conversations or counselling conversations that do not conform to its approved viewpoint.

127. Interventions commonly used to affirm discordant gender identity do not change a person's sex but rather the appearance of a person's sex. They include:

a. Social transitioning to live as another sex by using the clothing, hair styles, name, and pronouns of the desired sex,

b. Gonadotropin-releasing hormone analogues (GnRHa), commonly referred to as "puberty blockers", given in the early stages of puberty to stop this normal and healthy process and prevent development of secondary sex characteristics natural to one's sex,

c. Cross-sex hormones to increase secondary sex characteristics of the opposite sex, the cross-sex hormones being administered at high doses—testosterone levels 6 to 100 times higher than normal in females, "values typically found with androgen-secreting tumors" (Laidlaw, 2023. Par 135; Laidlaw Van Meter, et al., 2019; Laidlaw & Jorgenson, 2024), and oestradiol (a type of oestrogen) levels 2 to 43 times higher than normal in males (Laidlaw, 2023, par. 152),

d. Surgeries such as mastectomies, breast augmentation, castration or sterilisation, and cosmetic surgery to create the appearance of desired sex organs and facial features, and

e. Lifelong medical treatment.

128. To be clear, "gender affirming" medical treatments can sterilise and decrease sexual function and pleasure. (CHLA, 2016; Fenway Health, 2019; no date "a"; no date "b"; University of California San Francisco (UCSF), 2020a; 2020b; WPATH, 2022, p. S 102, S167; Laidlaw, Van Meter, et al., 2019)

129. A Children's Hospital Los Angeles (CHLA) informed consent form for parents regarding their child's medical gender treatments (2016) said:

a. **Puberty Blockers plus cross-sex hormones sterilise boys and girls permanently.** "If your child starts puberty blockers in the earliest stages of puberty, and then goes on to gender affirming hormones, they will not develop sperm or eggs. This means that they will not be able to have biological children.**"** (p. 32)

b. **Oestrogen for boys/men may affect fertility and sexual function and pleasure permanently.**

- "Sperm may not mature, leading to reduced fertility. The ability to make sperm normally may or may not come back even after stopping taking feminising medication….
- Testicles may shrink by 25-50%….
- Erections may not be firm enough for penetrative sex." (p. 28)

c. **Testosterone for girls/women may affect fertility permanently.**

"It is not known what the effects of testosterone are on fertility. Even if you stop taking testosterone it is uncertain if you will be able to get pregnant in the future." (p. 35)

130. The World Professional Association for Transgender Health (WPATH) accepts in its standards of care: (Coleman et al., 2022)

a. Pubertal suppression, hormonal treatment with sex steroid hormones, and gender-affirming surgeries may all have an adverse impact on future fertility. (p. S102)

b. Treating an [sic] TGD [transgender or gender diverse] adolescent with functioning testes in the early stages of puberty with a GnRHa [puberty blocker] not only pauses maturation of germ cells [sperm] but will also maintains [sic] the penis in a prepubertal size. (p. S119)

c. Transition-related hormones may affect mood, sexual desire, the ability to have an erection and ejaculation, and genital tissue health, which in turn can impact sexual function, pleasure and sexual self-expression. (p. S167)

d. Many gender-affirming surgeries can have significant effects on erogenous sensation, sexual desire and arousal as well as sexual function and pleasure. (p. S167)

e. Postsurgical complications can adversely affect sexual function by either decreasing the quality of sexual function (e.g., discomfort or pain with sexual activity) or by precluding satisfactory intercourse. (p. S167)

131. **Therapy that affirms the rejection of one's own sexed body and is intended to treat mental health problems in gender dysphoric people is a path that often leads to a medical protocol of experimental** (NICE, 2020b; Hembree et al., 2017; Gagliano-Juca et al., 2018) **and dangerous** (AAP, 2022; Murugesh et al., 2024) **puberty-blockers known themselves to increase depression and psychiatric disorders** (Lupron, 2023; Biggs 2019a; 2019b; Weipjes et al., 2020; Brik et al., 2020; Anacker et al., 2021; Laidlaw & Jorgenson, 2024) **and that may affect bone and brain development** (Laidlaw, Cretella, et al., 2019; Laidlaw, Van Meter, et al., 2019; Carmichael et al., 2021; Coleman et al., 2022; Hembree, 2017; GETA, 2022; Ludvigsson et al., 2023), **risky** (Hembree et al., 2017, NICE, 2020a) **high dose, toxic** (Coleman et al., 2012: pp. 190-197, 205-207; Laidlaw, Cretella, et al., 2019; Laidlaw, Van Meter, et al., 2019; Laidlaw & Jorgenson, 2024; Gomez-Lumbreras & Villa-Zapata, 2024, abstract) **cross-sex hormones reported themselves to increase psychiatric disorders** (Gomez-Lumbreras & Villa-Zapata, 2014, abstract), **expected infertility, potential loss of sexual function and pleasure,** (CHLA, 2016; Coleman et al., 2022; Hembree, 2017; GETA, 2022; Laidlaw, Cretella et al., 2019; de Silva et al., 2014), urinary and bowel symptoms (da Silva et al., 2024), **"a lifelong commitment to medical therapy"** (Council for Choices, 2020), **risky** (Miroshnychenko et al., 2024) **healthy breasts removal** (Handler, 2019; Quinn et al., 2017; Olson-Kennedy et al., 2018), **and potentially risky surgical destruction of reproductive organs assuring sterility** (Coleman et al., 2022, Georgas et al., 2018; Hembree, 2017; Ayad, 2022)**, a nearly 3 (2.8) times higher rate of psychiatric hospitalisations, a long term 2-2.5 times higher rate of deaths from heart attacks, strokes, and cancers** (Dhejne et al., 2011; NHS, 2022; Ayad, 2022; Hembree et al., 2017; Laidlaw, Cretella, et al., 2019; Laidlaw, Van Meter, et al., 2019; Glintborg et al., 2022)**, and a many times higher rate of completed suicides than for the general population** (Dhejne et al., 2011; Asscheman et al., 2011; Wiepjes et al., 2020; Erlangsen et al., 2023; exception Ruuska et al., 2024 with comment by Sullins, 2024a). **"Few guidelines address known treatment side effects and monitoring recommendations omit these."** (Taylor et al., 2024, Clinical guidelines, p. 7) **"Although patients may experience regret, after reassignment treatments, there is no going back to the non-reassigned body and its normal functions."** (Council for Choices, 2020)

132. **The puberty blocker used in the U.K. and the Netherlands, Triptorelin, is associated with depression that "may be severe"** according to research at the U.K. Gender Identity Development Service (GIDS). (Biggs, 2019a, p. 4) The label for the puberty blocker drug, Lupron, that is being given to gender distressed children in the United States, cautions providers, "Monitor for development or worsening of psychiatric symptoms". (Lupron, 2023, 5.2)

133. **Additional medical transition generated burdens patients may carry are** untreated pre- and co-existing psychiatric disorders with their own potential contribution to suicides, potentially going into life seeking relationships without

having a natural sex organ or capacity for natural sexual relations, feeling unsure of how to act as a person of the desired sex after they have already committed their body to appear permanently as the targeted sex, potentially not being able to speak about past life experiences that occurred when they lived as another sex, and other potential burdens that must not be lost from consideration.

134. **In support of gender medical interventions that cause these harms and risks that the MoU affirms instead of psychotherapy conversations that may resolve gender dysphoria or incongruence, how good is the best available research evidence?** The American Psychological Association's "Policy Statement on Evidence Based Practice in Psychology" says "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (APA, 2021c).

135. **Systematic reviews of the "Dutch studies" that have served as the foundational research evidence for the safety and effectiveness of gender-affirming treatment for minors** (de Vries et al., 2011, de Vries et al., 2014) **have been rated by NHS-England as "very poor" certainty** (NICE, 2020a; 2020b; NHS CPAG, 2024) **and "insufficient" by the Swedish Agency for Health Technology Assessment and Assessment of Social Services** (SBU) (Ludvigsson et al., 2023, reviewed de Vries 2014, all studies reviewed rated "insufficient" in the abstract and findings of all studies reviewed collectively rated "low" or "very low" in tables 2-4).

    a. **These Dutch studies have also been found to have had multiple invalidating flaws according to a definitive critique, of which the following passages are quotes. (Abbruzzese, Levine, & Mason, 2023, bold added)**

> **Two Dutch studies formed the foundation and the best available evidence for the practice of youth medical gender transition. We demonstrate that this work is methodologically flawed and should have never been used in medical settings as justification to scale this "innovative clinical practice**." Three methodological biases undermine the research: (1) subject selection assured that only the most successful cases were included in the results; (2) the finding that "resolution of gender dysphoria" was due to the reversal of the questionnaire employed; (3) concomitant psychotherapy made it impossible to separate the effects of this intervention from those of hormones and surgery.
> (Abbruzzese et al., abstract, bold added)

> **The Endocrine Society's [guideline] statements regarding the potential benefits of puberty blockers and cross-sex hormones in gender dysphoric adolescents are supported only by references to these two Dutch studies** (Hembree et al., 2017, p. 12, p. 16). **Similarly, the World Professional Association for Transgender Health (WPATH) "Standards of Care" guidelines version 7 (SOC 7)—the version under which the practice of medicalisation of gender dysphoric youth**

> **became widespread—only referenced the Dutch experience** (Coleman et al., 2012). Despite several newer studies available, the proponents of gender affirmation still correctly emphasise that "the best longitudinal data we have on transgender youth comes primarily out of the Dutch clinic...the Dutch studies in the Dutch model of care. That's the prevailing model that most of the American clinics have based their care upon' (Janssen, 2022, 00:47:42). de Vries in her response to us, also agrees with this: "...indeed, as of today, the Dutch papers, and especially the de Vries et al., 2014 study, are still used as main evidence for provision of early medical intervention including puberty blockers in transgender youth (de Vries et al., 2014)" (de Vries, 2022, p. 2).
> (Abbruzzese et al., p. 4, bold added)
>
> The inability of the Dutch research to elucidate the outcomes of cross-sex hormone treatments (separate from surgery) has been noted by **the National Institute for Health Care Excellence (NICE) in England, which appropriately excluded the 2014 Dutch study from its systematic review of evidence.**
> (Abbruzzese et al., p. 7, bold added. See National Institute for Health and Care Excellence (NICE), 2020a in my references.)

b. **Smith and colleagues (2001) conducted a follow-up study to the Dutch studies. Smith and colleagues reported that individuals who were rejected from or who withdrew from the Dutch program for gender reassignment in adolescence found noninvasive ways to deal with their gender dysphoria (or "gender problems"), and gender dysphoria significantly diminished.** Upon follow-up 1 to 7 years later, only 22% of the rejected subjects underwent gender reassignment as adults, while 78% refrained from it. Among those who remained medically untreated and participated in follow-up research, a remarkable 11 out of 14 "*did not feel any regrets about having refrained from SR [sex reassignment] or being rejected*...." Another 2 reported only slight regret for not having transitioned. Only 1 expressed strong regret (Smith et al., 2001, p. 477). Abbruzzese et al. commented,

> **Data from the study by Smith et al. (2001) raise the possibility that the majority of those rejected from hormonal interventions not only were unharmed by waiting but benefited from "nontreatment" with gender reassignment in adolescence.** Unlike the medically and surgically treated subjects, the "rejects" completed uninterrupted physical and psychological development, avoided sterility, maintained their sexual function, eliminated their risk of iatrogenic harm from surgery, and avoided the need for decades of dependence on cross-sex hormones.
> (Abbruzzese et al., pp. 14-15, bold added)

c. **In the United Kingdom, researchers at the Tavistock gender clinic conducted the only attempt ever made to replicate the Dutch longitudinal study on puberty blockers (de Vries 2011) with more than a handful of cases. This data set has been analysed separately three times. [Costa et al., 2015; Carmichael et al., 2021; McPherson & Freedman, 2023] The positive findings of the Dutch study were not replicated.**

   i. **The preliminary report compared psychological functioning between adolescents who were treated with psychotherapy alone and those who were treated with both puberty blockers and psychotherapy and found no difference at any time point—at 6 months, 12 months, or 18 months.** The psychotherapy alone group started with greater mental health problems. At 12 months, however, there was a 38% drop out rate, and at 18 months a 65% drop out rate for both groups (calculated from table 2) (with virtually identical drop-out rate for each group), so no generalisations can be drawn from this study. (Costa et al., 2015)

   ii. **Outcomes at 24 months were no change in psychological functioning, and gender dysphoria changed little.** (Carmichael et al., 2021) "Young people experienced little change in psychological functioning across the study. We found no differences between baseline and later outcomes for overall psychological distress as rated by parents and young people, nor for self-harm. Outcomes that were not formally tested also showed little change." (p. 18) Also, "Gender dysphoria and body image changed little across the study." (p. 20)

   iii. **Most recently, a reanalysis was conducted on *outcomes per individual participant* within the group taking puberty blockers. (McPherson & Freedman, 2023)**

      1. **It found higher proportions of individual participants deteriorated than improved.** "[T]he majority of participants [56% to 68%] experienced no reliable change in distress across all time points. Between 15% and 34% reliably deteriorate and between 9% and 20% reliably improve." (p. 5)

      2. **Self-report of clinical change was higher after 1 year than after 3 years. Self-report was higher than parent report at 1 year but decreased and converged with parent report over 3 years. Short-term studies using only the adolescents' self-report on their gender-affirming treatments may not be reliable.** More specifically, the adolescents reported higher rates of clinically significant change for themselves at 12 months than their parents did. This difference decreased over time "so that at the later measurement points, self-report and parent-report rates of clinically significant change converge at zero" with one

exception that "shows 20% (1/5) moved to the normal range at 36 months" only for behavioural problems (including attention problems and aggressive behaviour). (p. 9) In a different study using another data set, similar discrepancy was found between self-report and clinician report with self-report more optimistic than clinician report. (Kuper et al., 2020)

d. **Prominent Dutch researchers have noted: "[T]here is currently no general consensus about the best approach** to dealing with the (uncertain) future development of children with GD [gender dysphoria] and making decisions that may influence the function and/or development of the child — such as social transition." (Ristori & Steensma 2016, p. 18)

e. **The World Professional Association for Transgender Health said in 2022 in its Standards of Care updated to Version 8 that the Dutch studies were still the only studies on longitudinal effects of these body-altering interventions on youth or adults.** "Currently, the only existing longitudinal studies evaluating gender diverse youth and adult outcomes are based on a specific model (i.e., the Dutch approach) that involved a comprehensive initial assessment with follow-up." (p. S66) But that follow-up was for only 1 year into adulthood, not long-term. (de Vries et al., 2014) The authors of the WPATH Standard of Care acknowledged in essence that they have no data on what will happen to young people or adults if they continue on hormones for decades, and that having such data is important. They said,

> "…data are lacking on specific health issues facing transgender people who use GAHT [gender affirming hormone treatment] at a younger age, and those seeking to continue or begin GAHT in their sixth, seventh, eighth, or later decades. With an increasing proportion of transgender people beginning GAHT at younger ages, including some who begin at the time of puberty, studies to examine the impact of decades of such treatment on long-term health care are ever more important. (WPATH, 2022, p. S150)

f. **Government health authorities and related bodies have conducted a multitude of systematic research reviews that do not support the body-altering, "gender affirming" treatments the MoU uncritically accepts.**

g. **England: The National Institute for Health and Care Excellence (NICE) in England found no credible evidence that *hormone blockers* are effective or safe on several factors including "psychosocial impact".** It reviewed research conducted on the safety and effectiveness of gonadotrophin-releasing hormone (GnRH) analogues (commonly referred to as puberty blockers) published from 2000 through 14 Oct. 2020. The government review concluded the quality of the best available research is of "very low certainty". (NICE, 2020b, p. 4)

h. **England: The National Institute for Health and Care Excellence (NICE) also found no proof that *cross-sex hormones* are effective or safe for gender dysphoric children or adolescents**. Its research review published in Oct. 2020 concluded, "This evidence review found limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents with gender dysphoria, with all studies being uncontrolled, observational studies, and all outcomes of very low certainty. Any potential benefits of treatment must be weighed against the largely unknown long-term safety profile of these treatments." Total studies considered (whether selected to be included or excluded) had publication years from 2001 to 21 Oct. 2020. (NICE, 2020a)

i. **England: The Cass Review for NHS-England commissioned a systematic research review "re-run" on puberty blockers to create a review updated to studies published through April 2023. It found no studies that materially changed the conclusion of the NICE systematic research review on puberty blockers in 2020 (NICE, 2020b). It rated the evidence of all studies reviewed as having "very low certainty".** (Taylor et al., 2024, Interventions to suppress puberty)

j. **England: An NHS research report found that studies of puberty hormone blockers on which the WPATH Standards of Care (Coleman, 6 Sept. 2022) relied did not materially affect the conclusions of current evidence reviews.** The report, "Public Health Evidence Report Following Engagement Activity" (NHS, 15 Feb. 2024c) said, **"**To ensure comprehensive consideration of the SOC Version 8, the 200 citations within the relevant chapter, i.e. Chapter 12 Hormone Therapy, were further assessed".

k. **England: NHS-England published a research-based Clinical Policy on puberty hormone suppression (PHS) on 12 March 2024a, saying, "We have concluded that there is not enough evidence to support the safety or clinical effectiveness of PSH to make the treatment routinely available at this time."** The commissioning statement read, "Commissioning position: Puberty suppressing hormones (PSH) are not available as a routine treatment option for treatment of children and young people who have gender incongruence / gender dysphoria." (NHS-England, 12 March 2024a, Clinical Policy) The decision relied on research reviews on puberty hormone suppression that included 3 reviews just presented above regarding puberty blockers (NICE, 2020b; Taylor, et al., 2024, Interventions to suppress puberty; NHS, 15 Feb. 2024c) and a consultation of stakeholders (NHS, 7 July 2023) that were judged not to affect materially the findings of the existing reviews.

l. **England: The most comprehensive review of gender affirming treatment ever conducted is the Cass Review: Independent Review of Gender Identity Services for Children and Young People (Cass, April 2024) commissioned by NHS England. It is a 4-year-long systematic review of a broad range of aspects of the affirmative approach to gender care in children and adolescents**. The final report is based on 9 additional systematic reviews that cover psychiatric

history and disorders in child and adolescent gender patients, social transition, puberty blockers, cross-sex hormones, pathways of care, a survey of gender clinics, and treatment guidelines (2 parts). Further public consultation and consequent reviews were also conducted. Dr. Hillary Cass, the Chair of the review, concluded,

i. **"This is an area of remarkably weak evidence," and "The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress." Unfortunately, "Some practitioners abandoned normal clinical approaches to holistic assessment". (p. 13)** ***The Review calls for a fundamentally different treatment model from the non-exploratory affirmative approach of social transition, puberty blockers, and cross-sex hormones and will now prioritize psychotherapy.*** **Treatment teams will be multi-disciplinary and** ***led by psychiatrists, not gender specialists*****.**

ii. **Dr. Cass expressed concern about how afraid professionals are to discuss their views and how** ***debate*** **and** ***essential research*** **are stifled.**

> "There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour. This must stop. Polarisation and stifling of debate do nothing to help the young people caught in the middle of a stormy social discourse, and in the long run will also hamper the research that is essential to finding the best way of supporting them to thrive." (p. 13)

m. **Sweden: A research literature review on gender-affirming surgeries concluded, "The certainty of evidence for the benefits of genital, facial and body gender-affirmation surgery is generally very low…while major surgical complications probably are frequent after** ***genital*** **gender-affirmation surgery."** (Georgas et al., 2018)

n. **Sweden: In Spring 2021, Karolinska's Astrid Lindgren Children's Hospital stopped puberty blocker and cross-sex hormone treatments for minors under age 16 and, for adolescents ages 16 to 18, limited these treatments** to those older adolescents who are enrolled in clinical trials. They cited systematic research reviews by Swedish and U.K. government agencies and concluded medical interventions have a low certainty of benefits and significant risk of medical harm. (Karolinska Universitetssjukhuset Astrid Lindgrens Barnsjukhus, March 2021; SEGM, May 2021)

o. **France: After Karolinska Hospital in Sweden changed course, the National Academy of Medicine in France followed course, issuing a press release urging great caution regarding medical treatment of gender dysphoric**

children and adolescents. It warned there are "many adverse effects, even serious complications" and "side effects such as impact on growth, bone weakening, risk of infertility, emotional and intellectual consequences and, for girls, symptoms similar to menopause." It said "no genetic predisposition has been found" for the "disharmony" of gender identity. It described the "very strong increase" in cases as an "epidemic-like phenomenon" and a "primarily social problem" where "even clusters of cases in the close entourage" [clusters of cases in friendship groups] are occurring. (National Academy of Medicine, 2022, certified English translation)

p. **Sweden: In July 2021, all but one of Sweden's 6 university clinics that serve gender dysphoric minors decided hormone treatment should be given outside clinical trials only in exceptional cases, and Sweden had no clinical trials at that time.** The abstaining clinics planned to stay this course until the National Board of Health and Welfare updated Sweden's 2015 guidelines. **The reason for the change was the major shortcomings of a scientific basis for hormone treatment.** (Trysell, 2021)

q. **Sweden: The 2022 updated Swedish National Board for Health and Welfare guideline (NBHW, 2022) is one of the two highest rated guidelines reviewed in the Cass review of guidelines. (Tayor, Hall, et al., 2024, Clinical Guidelines) It says the *first line* treatment for all gender dysphoric individuals who are under 18 years of age will be psychiatric care and exploratory psychotherapy. The new guidelines emphasise that *identity formation is an evolving process in youth. Experiencing natural puberty is a vital step for development of gender identity and overall identity*.** Hormones will be administered at restricted and centralised locations in case-by-case exceptions for 16 or over and in research settings only, but there were no research trials in Sweden at the time. Prerequisites for an exception include transgender identity only, "classic" prepubertal onset only, with long-lasting clear suffering (minimum 5 years duration was mentioned) that persists into adolescence, pending extensive multidisciplinary evaluation. The board said it made this about-face turn from hormonal treatments because its research review concluded that **evidence for anti-pubertal and hormonal treatments is of low quality**, paediatric transition research is based on a markedly different population from the population currently seeking transition, and **reports of detransition and transition regret have increased among youths** who have transitioned in recent years. **Risks outweigh potential benefits. Guidelines for young adults, 18 to 25, are needed, because they also are still in process of brain development and maturation, and they are reporting detransition and transition-related regret.** (Summary report and comments in English, SEGM, Feb. 27, 2022; NBHW, 2 Feb. 2022, certified English translation)

r. **Sweden: "This systematic review of almost 10,000 screened abstracts suggests that long-term effects of hormone therapy on psychosocial and somatic health are unknown, except that GnRHa [puberty blocker] treatment seems to delay bone maturation and gain in bone mineral density."**

Therefore, this treatment with children should be considered experimental. This is the conclusion of a systematic research review of studies through November 9, 2021, and a few studies since then including Chen et al., 2023, on use of puberty blockers and cross-sex hormones for children under 18 years of age that was commissioned by the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (Ludvigsson et al., 2023) The corresponding author for the study, Professor Mikael Landen, at Karolinska Institutet and the University of Gothenburg, commented, "Against the background of almost non-existent long-term data, we conclude that GnRHa [puberty blocker] treatment in children with gender dysphoria should be considered experimental treatment rather than standard procedure. This is to say that treatment should only be administered in the context of a clinical trial under informed consent." (Karolinska Institutet, 2023)

s. **Finland: "The Recommendation by the Board for Selection of Choices for Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors" was rated by the Cass review along with the Swedish guideline as one of the two best gender dysphoria treatment guidelines** (Taylor et al., 2024, Clinical Guidelines). **The Finnish Recommendation said, (Council for Choices, 2020, certified English translation)**

    i. **"As far as minors are concerned, there are no medical treatment [sic.] that can be considered evidence-based."** (section 6 ethical assessment, bold added)

    ii. "The reliability of the existing studies with no control groups is highly uncertain, and because of this uncertainty, **no decisions should be made that can permanently alter a still-maturing minor's mental and physical development."** (section 6 ethical assessment, bold added)

    iii. ***"In adolescents, psychiatric disorders and developmental difficulties may predispose a young person to the onset of gender dysphoria."*** (section 7 conclusions, bold and italics added)

    iv. **"The *first-line* treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders."** (section 4 current care, bold and italics added)

    v. **"Brain development continues until early adulthood – about age 25, which also affects young people's ability to assess the consequences of their decisions on their own future selves for [the] rest of their lives."** (section 6 ethical assessment, bold added)

vi. **"For children and adolescents, these factors are key reasons for postponing any [medical gender] interventions until adulthood."** (section 6 ethical assessment)

t. **Norway: The Directorate of Health is in discussions with health services over possible changes in national guidelines for pediatric gender treatment, according to a statement at the end of June 2023. (Block, 6 July 2023) In March 2023, the Norwegian Healthcare Investigation Board (NHIB/UKOM) had published** that the use of puberty blockers, cross-sex hormones, and sex surgeries for gender dysphoric children and young people rely on insufficient research, are experimental and irreversible, carry risks, and must be restricted to research settings where they will be strictly regulated for safeguarding and will be rare. **As of this writing, we are still watching to see whether the government will heed the warning and recommendation. In Norway, by law, individuals cannot be sterilised before age 25. (SEGM, 9 March, 2023b)**

u. **Denmark: Danish physicians say Denmark is moving away from medical interventions to psychotherapy in cases of pubertal or post-pubertal onset of gender dysphoria. The purpose is to align with "the [evidence based] course corrections…of the medical community itself currently underway in Europe",** the Society for Evidence Based Gender Medicine reports. A Danish language article in a major medical journal, the *Journal of the Danish Medical Association*, confirmed most youth referred to the nation's centralised gender clinic will no longer be given a prescription for medical interventions but rather "a developmentally-informed approach that prioritizes psychosocial support and noninvasive resolution of gender distress". (SEGM, 17 August 2023) The Minster of Health made a public statement on 1 June 2023 that "the National Board of Health is also revising the entire guidance on health care for individuals with gender identity issues." (Løhde, 2023)

v. **Florida, U.S.: The Florida Department of Health (2022) prohibits treating minors with puberty blockers, cross-sex hormones, or gender surgeries. The Division of Florida Medicaid (health coverage for the poor) (2022) will not cover these interventions for minors or adults.** These decisions were based on commissioned comprehensive reviews of research, subject matter, and bioethics. The Florida Medicaid (2022) review came to these conclusions:

   i. **Research evidence for puberty blockers, cross-sex hormones, and gender surgeries for minors and youths is of uncertain quality, and extensive debate over their use may be needed, according to a Florida-commissioned systematic research review. of Florida Medicaid commissioned *a systematic review of the best systematic reviews*** published in English on the use for minors or youths (age 25 or younger) of puberty blockers, cross-sex hormones, and gender surgeries through April 30, 2022. The reviewers concluded, "Due to the important limitations in the body of evidence, there is great uncertainty about the effects of puberty

blockers, cross-sex hormones, and surgeries in young people with gender dysphoria." They advised, "It is important to note that when there is low or very low certainty evidence, it is rarely appropriate to make decisions that will be applied to the majority of the patients (equivalent to strong recommendations)." They further advised, "At a policy level, extensive debate may be needed." (Brignardello-Petersen & Wiercioch, 2022, pp. 2, 5)

ii. **Another research review commissioned by the Florida Medicaid found no evidence that puberty blockers and cross-sex hormones are superior to psychotherapy.** The reviewer, Cantor (2022, pp. 3, 11-15), looked at 11 longitudinal studies on the effect of puberty blockers and cross-sex hormones on mental health in pubescent and adolescent-age minors, and I have added 6 more such studies for a total of 18 studies (3 were more recently published in 2023, others published in 2021, 2020, and 2011). In 9 of the studies, mental health failed to improve. [Carmichael et al., 2021; Dhejne et al., 2011; Glintborg, et al., 2023; Hisle-Gorman et al., 2021; Kaltiala, et al., 2020; Kaltiala, Holttinen, & Tuisky, 2023; Kuper et al., 2020; Tordoff et al., 2022a; 2022b] In 3, mental health improved at least some or for one sex or for a minority, but possible benefits from psychotherapy or psychiatric medication were not taken into account. [Chen et al., 2023 and critique by de Vries & Hannema, 2023 and by Ludvigsson et al., 2023; Lopez de Lara et al., 2020; McPherson & Freedman, 2023] In 4 studies, mental health improved, but because psychotherapy and medical interventions were both provided, which intervention(s) caused the improvement could not be identified. [de Vries et al, 2011; de Vries et al, 2014; van der Miesen et al., 2020; Allen et al., 2019. The 2 remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical gender effects, and neither found gender medical intervention to be superior to psychotherapy-only. [Costa et al., 2015; Achille et al., 2020]

1. Correction to Cantor's summary: Cantor explained he put Tordoff et al., 2022 in the category of studies that did not control for mental health treatment. The Tordoff researchers said, however, that they did control for psychotherapy but not for psychiatric medications. Accordingly, I moved Tordoff to the "failed to improve" category. (Tordoff et al., 2022)

2. Follow-up studies that controlled for or reported rates of psychiatric medications but not psychotherapy were Kuper et al. (2020) and Glintborg et al. (2023). Hisle-Gorman et al. (2021) looked at both psychotherapy and psychiatric drugs. These studies found that gender drugs did not improve mental health.

Tordoff et al. (2022) controlled for psychotherapy but not psychiatric medications but found mental health did not improve.

3. Achille et al. (2020) controlled for both psychotherapy (90% were in counselling) and psychiatric medications (34% were on psychiatric medications) over the 1-year follow-up study. They found overall that puberty blockers and hormones were not significantly more effective than psychotherapy and psychiatric medications, although there were some trends, and one measure was significant for depression for males on puberty blockers. We do not know how representative the findings were for patients in the single-gender clinic, because we do not know what percent of the patients agreed to participate, and because we do know only slightly more than half of participants who did agree to participate (53%) completed all questionnaires and were included in the study.

w. **German researchers conducted a review of studies through August 2023 on use of puberty blockers and cross-sex hormones for gender dysphoric minors that were published since the National Institute for Excellence in Health Care (NICE) in England conducted its research reviews on these interventions published through Oct. 2020.** The German researchers used the same accepted methods and standards as NICE England. They concluded,

> There is currently no evidence of a potential cost effectiveness for the use of PB/CSH [puberty blockers or cross sex hormones] in minors with GD [gender dysphoria] when compared to one or more psychosocial interventions, social transition to the preferred gender or no intervention. (Zepf, et al., 2024, p. 25)

x. **International: The World Health Organization announced it would not include children, adolescents, or gender surgeries in the nonbinding gender-affirmative guideline it was planning. It has acknowledged, regarding affirmative medical interventions, "the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender-affirming care for children and adolescents." (WHO, 2024) It failed to acknowledge that the longer-term evidence for adults is no better, as registry studies I am about to present will show. (Haynes, 2024e)**

136. Notably, there are now several registry studies of gender-affirming interventions that have largely found that these interventions do not improve mental health, or they worsen it. Rigorous registry studies currently appear to be the best available research. The studies variously included adolescents and young adults only, adults only, or all ages. These studies are large, including everyone in a population, often a national population. They are longitudinal, some extending over

decades—20 to 30 years. Most of these studies had comparison groups of people representative of the same large population and extending over the same period of time. Some of the studies have a comparison group of all untreated people in the national population. The data usually come from centralised government electronic medical records or sometimes from insurance company records created by medical or mental health professionals, often in specialised gender clinics. The data are much more objective than self-report survey responses from volunteers solicited from gender clinics or solicited online from transgender-identity communities. Volunteers may not be representative of all people in a clinic or of all people in a population who have gender diagnoses. Also, volunteers often do not reliably complete an entire survey or stay in a study for the whole time. Findings of registry studies of medical gender interventions are as follows:

a. **Sweden 2011: Medical gender interventions—cross-sex hormones and surgeries—were not sufficient to treat mental disorders, but rather psychiatric treatments were required, according to a national registry study discussed above of all 324 transgender-identified adults in Sweden over 30 years and 3,240 matched peers ("controls") from the general population for comparison. Psychiatric disorders persisted at a rate nearly 3 (2.8) times higher, and the completed suicide rate was 19 times higher than for matched peers from the general population** (Dhejne et al., 2011, also discussed elsewhere in this report).

    i. **The authors concluded psychiatric disorders persisted after medical gender interventions**, saying, (Dhejne et al., 2011, p. 6, footnote notations in quote omitted)

        > Inpatient care for psychiatric disorders was significantly more common among sex-reassigned persons than among matched controls, both before and after sex reassignment. It is generally accepted that transsexuals have more psychiatric ill-health than the general population prior to the sex reassignment. It should therefore come as no surprise that studies have found high rates of depression, and low quality of life also after sex reassignment. Notably, however, in this study the increased risk for psychiatric hospitalisation persisted even after adjusting for psychiatric hospitalisation prior to sex reassignment. This suggests that even though sex reassignment alleviates gender dysphoria, there is a need to identify and treat co-occurring psychiatric morbidity in transsexual persons not only before but also after sex reassignment.

    ii. **Yet 5 years later, after this 30-year Swedish study found medical gender interventions did not improve mental health, its lead author led an international research review erroneously claiming to show mental health improved over time after medical gender interventions.** "In summary, this review indicates that, although the

levels of psychopathology and psychiatric disorders of trans people attending transgender health-care services are higher than the cis population [people who identify with their sex] at the time of assessment, they do improve following gender-confirming medical intervention, in many cases reaching normative values." (Dhejne et al., 2016) The studies reviewed, however, were not sufficient to warrant the conclusion of mental health improvement, because nearly all the studies were too short to find endpoint outcomes, only following participants for 3 months to 5 years. The 30-year study by Dhejne et al. (2011, reported above) had found suicide rates increased after 10 years. Peggy Cohen-Kettenis, one of the originators of the gender-affirming medical approach, the Dutch protocol, later concluded that follow up studies need to run at least 20 years. (Biggs, 2023) The studies reviewed in this 2016 review that were longer than 5 years included only one 9-year study that had only 22 participants and lost 30% of them to follow-up, leaving a vanishingly small number of participants. The other exception was a 13-year study that lost half its participants to follow-up, making it impossible to draw any generalisations about outcomes.

iii. A limitation of the 30-year study as the authors had noted was that they did not have a comparison group of transgender-identified patients who did not receive gender medical interventions, so they did not know whether psychiatric conditions might have been even worse without the medical interventions. (Dhejne et al., 2011)

iv. Registry studies that were decades-long found that patients who had gender hormones and surgeries had a many times higher rate of completed suicides than for the general population (Asscheman et al., 2011, over 30-year study, 18 years average follow-up; Wiepjes et al., 2020, 45-year study; Erlangsen et al., 2023, 42-year study, 4 times higher suicide rate) as was found in this Swedish study (Dhejne et al., 2011). These studies generally do not provide a comparison of those who had gender medical interventions and those who did not.

b. **Sweden: Providing partial help, a subsequent national Swedish registry study did compare in all people in Sweden who had a gender diagnosis in 2015 (2,679) who received sex surgeries (38%) and who did not receive sex surgeries (62%) over the previous 10 years and found no difference** in frequency of hospitalisations following serious suicide attempts. It did not compare completed suicides. (Branstrom & Pachankis, corrected 2020)

c. **California, US, 2021: The suicide attempt rate more than doubled from the rate during approximately 2 years before genital surgery (1.4%) to the rate during approximately 2 years after genital surgery (3.3%) for males and did not change for females (0.8%).** Proportion of genital surgery patients who attempted suicide overall (before, after, and both before and after) were

higher for males (4.4%) than females (1.7%). Suicide attempts for gender surgery patients were 3 times that of the general population for males, and the same as the general population for females. Findings were based on the California Office of Statewide Health Planning and Development dataset that provided records of all emergency room and inpatient psychiatric encounters for male (869) and female (357) gender-diagnosed patients who underwent gender surgeries with notation of those involving suicide attempts. Emergency room and inpatient psychiatric encounters would generally be for the most severe psychiatric problems and were high overall for both males (22%) and females (21%) who underwent genital surgeries. (Dallas et al., 2021) The study did not have a non-genital-surgery group of gender patients to compare with the genital-surgery group of gender patients. Researchers did not report the age of the patients, but presumably the large majority would have been adults.

d. **United States, studies in 2021, 2022: A registry study used a comprehensive data set of an entire, large, U.S. cohort of 3,574 gender-discordant youths in U.S. military families that followed them over a period of 8.5 years (2010-2018) and included their psychiatric diagnoses and a gender-concordant comparison group of 6,603 siblings. The study found that, following initiation of "gender affirming pharmaceuticals" (puberty blockers and/or cross-sex hormones, not assessed separately, initiated at a median age of 18), mental health and suicidality worsened.** (Hisle-Gorman et al., 2021)

    i. **This rigorous study provided pre-treatment diagnoses, did not rely on subjective self- or parent-report, provided comparisons of gender-discordant adolescents who were given puberty blockers and/or cross-sex hormones to matched peers (siblings) who did not evidence gender identity discordance, and compared pre- and post-treatment use of mental health services and psychiatric medications.** Specifically, the study looked at all 3,754 transgender and otherwise gender-discordant youths who were dependents of U.S. military members domestic and abroad, of whom 26% (963) received "gender affirmative pharmaceuticals" and 6,603 of their siblings who did not evidence gender discordance, over 8.5 years of retrospectively available data (2010-2018). All youths were less than 18 years old when they entered the U.S. military health care system. Gender-discordant youths who received gender treatment initiated it at a median age of just over 18 years (18.2). Data were collected from the Military Healthcare Data Repository of all records of inpatient and outpatient care and all outpatient pharmaceutical prescriptions provided to all military members and their family members. While the military population tends to reflect the general U.S. population except that it tends to be more conservative, male, and white, the parents of youths who received gender treatment were overall somewhat higher rank (fewer were of junior rank) and therefore may have been more educated and liberal. (Hisle-Gorman, 2021, Tables 1 and 4; Pew Research Center, 2016)

ii. **The researchers found, not only that gender-discordant youth had very high rates of psychiatric disorders (89%, compared to 50% for their gender-congruent siblings which was also very high), but also that their disorders were usually sufficiently severe that 75% were given psychiatric medications compared to 38% of gender-concordant siblings (also very high). Healthcare visits were more than twice as high for gender-discordant youths than for gender-concordant siblings. Gender-discordant youths received more mental healthcare than their siblings, especially "for adjustment, anxiety, mood, personality, psychotic disorders, and suicidal ideation/attempted suicide."** (Abstract) For gender-discordant youths who received medical gender treatment, gender and psychiatric pharmaceutical records were tracked an average of a little over 7 (7.1) years (range 5.5 to 7.8 years) *prior to* and on average 1.5 years (range 0.8 to 2.8 years) *following* initiation of this treatment. The follow-up period is still too short to tell us long-term or endpoint outcomes, but this study **does likely validly tell us short-term outcomes.** (Hisle-Gorman, et al., 2021)

iii. **Use of psychiatric medications significantly *increased* in nearly all medication classes explored.** Following the initiation of gender pharmaceutical treatment, 89% of gender-discordant youths were on psychiatric pharmaceuticals during the study period compared to 75% for all gender-discordant youths over the full course of the study. **(**Hisle-Gorman et al., 2021, p. 1448) **"Findings indicated that mental healthcare visits were not significantly changed, and psychotropic medication use rose following gender-affirming pharmaceutical treatment after adjusting for potential confounders. Results are not consistent with adult and adolescent self-report survey research indicating improvements in mental health symptoms following gender-affirming care."** (Hisle-Gorman et al., 2021, p. 1,450, bold added)

iv. These findings indicate that the vast majority of gender-discordant youths experienced psychiatric disorders sufficiently severe to warrant psychiatric medications and suggest their capacity to give informed consent to potentially permanently body-harming interventions was as a result likely impaired, but the bodies of 26% of them were altered anyway.

v. **For those 26% who received gender-affirmative pharmaceuticals, in the nearly 1 (.8) to nearly 3 (2.8) years, or 1.5 years on average, that they were followed after gender drug treatment, the health of their natural bodies was placed at risk, their overall number of healthcare visits did not decrease, their use of psychiatric medications**

***increased*, and their suicidality, as measured by health care visits, *worsened*.**

vi. **Gender drugs discontinuation rates were notably high, but the youths' bodies had already been subjected to gender drugs with their potential lifetime harms and risks. A related follow-up study from this same data set** followed 952 transgender-identified people including "children and spouses of active duty, retired, and deceased military members" from 2009 to 2018. It found that, within 4 years of beginning gender drugs, the rate of discontinuing these drugs was a little more than 1 out of 4 (26%) for youths who were started on gender drugs before age 18 and more than 1 out of 3 (36%) for individuals who started gender drugs after age 18, for an overall rate of 3 out of 10 (30%) who were given gender drugs. Cost was not likely a reason for discontinuation. Family income and whether treatment was initiated before or after military healthcare covered gender dysphoria treatment were not influences on discontinuation rates. All who discontinued gender pharmaceuticals did continue to receive other medical care through military healthcare insurance for at least 90 days. (Roberts et al., 2022) If those who began before age 18 had been followed to the same age as those who began after age 18, and if all gender patients had been followed for a longer period, ideally at least 10 years, it is reasonable to expect the discontinuation rate would likely have been higher. The study does not tell us the reasons for discontinuing, but whatever the reasons, these individuals' health had already been placed in harm's way, and we know, at least in the case of the young people (Hisle-Gorman, et al., 2021), their medications for mental health problems and healthcare visits for suicidality increased. (Roberts et al., 2022)

e. **United States: Risk of suicide attempt, death, suicide/self-harm, and post-traumatic stress disorder were significantly greater for adults aged 18 to 60 who were in health maintenance organizations and who underwent gender affirming surgery (1,501) compared to adults who did not have such surgery (15,608,363) and compared to adults who had vasectomy or bilateral tubal ligation surgery (142,093).** Individuals selected in all groups for the study had had an emergency visit. Individuals' electronic medical records were followed retrospectively for 5 years, starting after surgery in the surgery groups, during the twenty-year period from 2003 to 2023. The database involved 90 million patients from 56 U.S. healthcare organizations. To the researchers' knowledge, this was the first time a study this size has been described in the research literature. Causation cannot be inferred from this study that did not compare risks before and after interventions, but possible causes of increased risks may be high prevalence of psychiatric conditions, pre-existing sex surgery, quality of surgery outcome, effects on health, effects on relationships, regret, or minority stress. Results from this research do not appear to support that

gender affirming surgery is sufficient to resolve mental health difficulties or suicidality for adults. (Straub et al., 2024)

f. **Denmark: A robust registry study similarly found use of drugs for psychiatric disorders increased during gender drug treatment for adolescents and adults. (Glintborg et al., 2023)** Researchers collected national registry data on everyone in Denmark, ages 3 and older (middle 50% were ages 15 to 24) who was diagnosed with gender identity disorder or contact for gender identity condition (3,812) at Denmark's 3 highly specialised gender centres during the first 21 years of this century and 5 birthdate matched peers of each sex from the general population for each individual who had a gender diagnosis (total 38,120). Researchers then followed treatment for gender discordance for up to 10 years (average 4.5 years) and found that, immediately after the diagnosis and presumably after the start of affirmative treatment they may have had, including cross-sex hormones for 55% and "gender affirming" surgery for 20%, the number of them having hospital contacts for psychiatric diagnoses spiked in the first year to about twice as high, possibly as a result of having received a psychiatric evaluation, then followed a trend of gradually decreasing over the years *only as* use of prescribed psychiatric medications simultaneously *increased*. (Figure 2) If opposite-sex hormones had decreased psychiatric disorders, use of psychiatric medications would have been expected to *decrease*. Prevalence of hospital contacts for psychiatric disorders during the 2 years before gender diagnosis and (presumably) treatment was more than 5 times higher for gender identity discordant patients than for matched gender concordant peers (p. 342) "and remained elevated throughout follow up", especially for gender-identity discordant males. (Abstract) Only psychiatric diagnoses severe enough to have resulted in hospital contacts were included in the study data, otherwise rates of psychiatric disorders almost certainly would have been higher (p. 342). The number of hospital contacts for suicide attempts while on hormone treatment indicate there were 510 suicide attempts by 97 gender-discordant females and 198 suicide attempts by 47 gender-discordant males. The study was not able to tell us whether these hospital contacts for suicide attempts represented an increase after hormone or surgical treatment, but we do know hospital contacts for psychiatric reasons in general did increase.

g. **Finland: Another longitudinal, national registry study of all ages, this one in Finland, also found psychiatric disorders increased or were no different after gender medical interventions. The researchers concluded that contacting specialised gender services is increasing at ever younger ages and with more severe psychiatric needs. "Manifold severe psychiatric disorders persist" and actually increase proportionately for those who undergo medical gender interventions.** This is according to a large, multi-decade—over 23 years—longitudinal (1996 to 2019), national-registry-based study on all 3,665 individuals who contacted the gender identity services during this time with a sizable comparison group of matched peers from the general population (8 peers per gender patient, 4 per sex, matched for age, place of residence at

birth, and the 5 year period in which the gender patient contacted gender services, total 29,292). Medical gender services were extended to minors in 2011. Of individuals contacting gender services, 38% underwent gender medical interventions, most commonly cross-sex hormones (37% cross-sex hormones, 11% genital surgeries). Average follow-up time was just under 6 years (5.6) and maximum 26 years. The study focused on severe psychiatric disorders requiring specialist psychiatric services only and did not address mild to moderate psychiatric disorders that are treated in primary care. Among people contacting gender services, 72% had any history of severe psychiatric disorders. (Table 1) (Kaltiala, Hottinen, & Tuisku, 2023) **Referring to the U.S. military registry study (Hisle-Gorman et al., 2018), the Finnish researchers said, "Their findings and ours do not suggest that medical GR [gender reassignment] interventions resolve psychiatric morbidity among people experiencing gender distress." (p. 6)**

h. **As this study from Finland was going through peer review, Kaltiala, who opened the gender services in Finland and was the lead author of this study, published a public statement saying, "Gender affirming care is dangerous. I know because I helped pioneer it. My country, and others, found there is no solid evidence supporting the medical transitioning of young people. Why aren't American clinicians paying attention?"** (Kaltiala, 2023)

i. **Among the gender-diagnosed patients in the Finnish data set just described who entered gender services before age 23 (2,083 individuals), however, suicides were higher in young people who did not proceed to gender medical interventions (hormones, mastectomies, and/or genital surgeries) than in those who did proceed to them (38%).** The study as originally published said *suicides* were *higher* in patients who received gender surgeries. I noted an apparent discrepancy in the data, however, and sent communication to Sullins. On closer examination, Sullins found that the opposite was true, that *suicides* were *lower* in patients who received gender surgeries, and Sullins promptly published a comment to this effect. (Ruuska et al., 2024; Sullins, 16 March 2024, comment on Ruuska, 2024) Their *suicides were lower,* yet the related Finnish study for gender-diagnosed patients of all ages had found that *their severe mental health problems did not improve or even worsened* after gender medical interventions overall. (Kaltiala, Hottinen, & Tuisku, 2023) How does this make sense? It is well-known that suicides are associated with psychiatric disorders. (Cavanagh et al., 2003; O'Carroll, & Potter, 1994) The follow-up time in the study on suicides was on average 6.5 years. By comparison, the 30-year Swedish study similarly found that psychiatric disorders were higher for patients after cross-sex hormones and sex surgeries than for matched peers in the population, but suicides did not rise until 10 years after gender interventions. (Dhejne et al., 2011) That Swedish study did not have a comparison group of gender patients who did not go on to gender medical interventions. In the Finnish suicide study, the follow-up time of 6.5 years is not long enough to see endpoint outcomes. It is possible that gender patients who proceeded to medical interventions were preselected to have fewer

psychiatric disorders as a precondition for proceeding. Another possible explanation, as Sullins suggested, might be "the presence of assessment, screening and monitoring processes that may inhibit some of the negative consequences of psychiatric morbidity, for example by ensuring better social support or medication compliance, than may be the case in other settings." It would be important to know whether such support was provided to an equal degree and over an equal length of time for those who obtained gender medical interventions but did not go on to have sex surgeries.

j. **Germany: It has been claimed that medical gender affirming treatment with parent support decreases depression and suicidal thoughts or attempts. (Green et al., 2022) Research so far, however, has not looked separately at parent support and affirmative interventions. It may be that it is parental support, not necessarily affirmative interventions, that improve mental health. A study that did look at the quality of parent-child relationships separately from whether parents affirmed gender interventions for their children concluded, "Likewise, our study found that, social support in general (from family and peers), but not necessarily in terms of affirming one's child gender status, plays a role for the psychological outcomes."** (Sievert et al., 2021, p. 90)

    i. Gender diagnosis, family support for transitioning, and psychological functioning were professionally assessed and reported, not simply based on survey self-report. At a university medical centre gender clinic in Germany, parents were asked to take a nationally standardised questionnaire regarding their child and family on the first visit before any further evaluation or any treatment. Children were subsequently selected to be participants in the study if they were under 12 years of age, they were given a diagnosis of gender dysphoria, and their parents agreed to the participation. As a result, 54 children, representing at least 71% of eligible children (estimated from Figure 1), were included in the study. The findings from the questionnaire were as follows: "The Total Problem Score for overall psychological functioning was significantly elevated" in almost all areas evaluated for 39% of both gender dysphoric girls and boys compared to children in the German population. (p. 87) Children were also assessed as to "whether they lived in their preferred gender role in the following three everyday life areas: at home/with family, with friends/peers, and at school." In addition, parents were asked "how far they supported their child's current gender role or social transition." (p. 84)

    ii. **The researchers found, "Peer problems and worse family functioning were significantly associated with impaired psychological functioning, whilst the degree of social transition did not significantly predict the outcome.** Therefore, claims that gender affirmation through transitioning socially is beneficial for children with GD could

not be supported from the present results. Instead, the study highlights the importance of individual social support provided by peers and family, independent of exploring additional possibilities of gender transition during counseling." (Abstract)

iii. **The treatment that the clinic provided was psychotherapy.** "Psychotherapy offered include [sic] psychodynamic individual and family sessions with a frequency tailored to the child's individual needs." (p. 83) Similar research is needed for gender dysphoric adolescents and their parents.

iv. **In a systematic review for the final Cass report to NHS England, this study was rated as among the best available.** It was one of the 2 out of 11 studies on social transitioning that was rated as moderate quality. The others were rated as having low quality. (Hall et al., 2024, Impace of Social Transition, Figure 2 on p. 3, for Cass, April 2024, Figure 33 on p. 161)

v. **In a similar study of adolescents referred to this same Hamberg, Germany gender clinic, poor peer relations and poorer family functioning were each independently and strongly associated with the elevated psychological impairment found in the majority of gender dysphoric adolescents compared to adolescents in the general German population. Researchers pointed out the need for a holistic and integrated approach and suggested assisting the whole family.** (Levitan et al., 2019, pp. 1496-1497)

137. Not only do *research reviews* show that the affirmative-only approach the MoU appears to require *does not have research support*, but also *position statements and guidelines* from professional organisations are evidence that the affirmation-only approach also *does not have professional consensus support*. Increasingly, professional organisations are expressing their acceptance of the research findings critical of the affirmative treatment approach and accepting the need for *psychotherapy that is exploratory, treats predisposing conditions of gender dysphoria, and should not be labeled "conversion therapy". This therapy is what change exploring therapists do with openness to client goals and the MoU prohibits.* Professional organisations that are still maintaining affirmation-only treatment guidelines are experiencing that these guidelines have come under research examination and challenge from their own members—sometimes from their own authors.

a. **International*: The "Endocrine Society Clinical Practice Guideline" published by the Endocrine Society in the U.S., with its 6 international co-sponsoring professional organisations, itself cautions that the research on which nearly all of the guideline recommendations are based is low quality, very low quality, or none, the guideline is not a standard of care, and the guideline cannot guarantee any outcome.*** The "Endocrine Treatment of Gender-

Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline" furnished recommendations for use of hormone blockers, cross-sex hormones, and sex surgeries. It cautioned, "The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care." (Hembree et al., 2017, p. 27).

b. **Australia: The National Association of Practising Psychiatrists (NAPP, 2022) issued a guide stating that gender dysphoria/incongruence may be a manifestation of "pre-existing family, social, psychological or psychiatric conditions or predisposing factors." It says psycho-social interventions should be first-line treatments.** "Clinicians can apply a range of psychological interventions (e.g. supportive psychotherapy, CBT [cognitive behavioural therapy], dynamic psychotherapy and family therapy) to assist the young person in clarifying and resolving these contributory factors. Such approaches are consistent with established principles of comprehensive and systemic youth health care." The guide cautions that medical interventions are "not fully reversible and can cause significant adverse effects" and lack long-term outcome studies. "As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross- sex hormones or sexual reassignment surgery lead to better future psycho-social adjustment." The guide does not accept a pre-determined outcome of therapy, as is appropriate if a goal of therapy is coming only from the therapist. However, patients have a right to predetermine their desired goals of therapy and to explore their capacity to achieve them in part or in full. If gender dysphoria or incongruence is "a manifestation of pre-existing…conditions or predisposing factors" as the NAPP states, and these are treated with psycho-social interventions, then it can reasonably be expected that resolution of distress and gender dysphoria or incongruence may be a potential outcome, and patients should be allowed to have this outcome as a therapy goal.

c. **The Royal Australian and New Zealand College of Psychiatrists observed in 2021, "There are polarised views and mixed evidence** regarding treatment options for people presenting with gender identity concerns, especially children and young people." Yet they were able to agree, "Comprehensive assessment is crucial. Assessment and treatment should be evidence-informed, fully explore the patient's gender identity, **the context in which this has arisen, other features of mental illness and a thorough assessment of personal and family history**." To be able to say more beyond this, they called for more research, saying, "Gender Dysphoria is an emerging field of research, and, at present, **there is a paucity of evidence**. Better evidence in relation to outcomes, especially for children and adolescents is required." (RANZCP, 2021. Bold added.)

d. **The Royal Australian and New Zealand College of Psychiatrists issued an updated position statement (RANZCP, 2023) that maintained there is a range of treatment modalities but added a new emphasis on "caution on the use**

of hormonal and surgical treatment" (p. 10), saying, **"There is limited high quality evidence**." (p. 9)

i. The update also acknowledges, **"For some people, gender identity and/or gender expression can change over time."**

ii. **A new emphasis was placed on acknowledging and addressing harms reported by detransitioners and treatment for them**. Some people who detransition "identify with their sex as registered at birth and report that in retrospect they **feel that their gender dysphoria was due to other issues (e.g., trauma, internalised homophobia or mental health problems)."** They have reported mental health problems, feelings of grief and loss, and difficulty accessing healthcare services. (pp. 12, 13) The seriousness of claims of harms is clearly laid out.

> Some individuals **report that they have been harmed by previous gender-affirming care** and **some have launched legal proceedings against health care providers**. Sufficient information should be provided to allow for **informed consent** for gender-affirming medical and surgical treatments. This **should always involve thorough, open discussion of the possibility of disappointment, continued gender dysphoria, regret about irreversible effects of treatment, regret about reduced fertility, and shifts in gender identity or treatment wishes.** (p. 12)

iii. **The update supports that "…psychological intervention such as psychodynamic psychotherapy enables a collaborative and holistic approach to mental health care" (p. 11) and is not "conversion therapy".**

e. **The Italian Psychoanalytic Society** reportedly has written a letter expressing great concern over experimenting on children with puberty blockers. (Feminist Post, 2023)

f. **The 128th German Medical Assembly consisting of 250 delegates from 17 German medical associations is reported to have voted for a resolution restricting** puberty blockers, cross-sex hormones, and surgeries for youth suffering from gender dysphoria. (SEGM, 10 May 2024) They noted the life-long consequences of these interventions including sterilisation, the absence of reliable evidence for them, and the recent finding of a Dutch study that "gender non-contentedness" peaks around age 11 (around puberty), then resolves for the vast majority by age 26. (Rawee et al., 2024)

g. **The European Society for Child and Adolescent Psychiatry says regarding the care of gender dysphoria in children and adolescents, "ESCAP insists that respect for all kinds of different views and attitudes is an essential part of an**

ongoing open professional debate that we wish to stimulate." The MoU, by contrast, requires a single affirmation-only viewpoint and enforces it. The position of ESCAP only makes it more obvious that there is not a professional consensus in support of MoU viewpoint discrimination. ESCAP accepts that research reviews from the U.K., Sweden, Finland, and Germany "were consistently critical of the current evidence base" and that the World Health Organization (WHO) will not include minors in its forthcoming guidelines because the evidence base is weak and insufficient. (Radobuljac et al., 2024)

h. **Indiana State Medical Association, in a position reversal, passed a resolution in 2023 opposing medical and surgical gender transition treatment for children,** listing its harms in detail, and advocating for this position with state lawmakers and regulatory agencies. (Arnold, 13 Sept. 2023)

i. **The American Society of Plastic Surgeons, whose members come from the U.S. and Canada, became the first major national medical association in the U.S. to challenge the consensus of medical groups for "gender affirming care" for minors".** (Saper, 12 August 2024**).**

j. **Even the American Psychiatric Association** that supports physical interventions acknowledges in its diagnostic manual entry for gender dysphoria, **"After gender reassignment, adjustment may vary, and suicide risk and mental health problems may persist."** (APA, *DSM-5-TR*, p. 515)

k. **The American Academy of Pediatrics (AAP) recently recommitted to its solely affirmative intervention position and only afterwards to follow up by conducting a "systematic review of evidence" for the first time following public pressure from its members** (Sapsford & Armour, 2023; Elliott, 2022) who are questioning its policy (Rafferty et al., 2018). **Positions that organisation boards take do not necessarily represent the positions of their members, and the AAP position does not have professional members' consensus in support of it.**

    i. **"Remarkably, not only did the AAP [American Academy of Pediatrics] statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its cited sources, which repeatedly said the very opposite of what AAP attributed to them."** (Cantor, 2019, abstract) **This is the blistering criticism of the AAP position published in a professional journal by James Canator.** Dr. Cantor's many credentials include that he "is the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology",* according to one of his at-least 14 expert opinions submitted in court cases. (Cantor, 2022; Cantor, 2023)

    ii. **"The policies of the Europeans are much more aligned with the evidence than are the Americans." (Parks, 2022) These are the words**

of Gordon Guyatt, the clinical epidemiologist at McMaster University who is credited with initiating the concept and term, "evidence-based medicine" in 1991-1992. (Sur & Dahm, 2011) "Guyatt told The Times he believed that the AAP will most likely find low-quality evidence for pediatric gender care." (Parks, 2022)

iii. **The state of Florida (U.S.) concluded regarding professional organisation position statements that support medical gender interventions, based on several research reviews and subject expert reports,**

> **While clinical organisations like the AAP [American Academy of Pediatrics] endorse the above treatments, none of those organisations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary,** the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS [generally accepted professional medical standards] and are experimental and investigational. (Florida Medicaid, 2022, p. 39)

l. **The World Professional Association for Transgender Health's (WPATH) Standard of Care (SOC) said it is not possible to conduct a systematic research review on medical interventions in adolescents. This is false. The Cass research review for NHS commissioned a systematic review of the 200 citations in the WPATH SOC, version 8, Chapter 12: Hormone Therapy, for evidence on puberty hormone blockers and found there was no citation that materially changed the critical conclusion of the NICE 2020 systematic research review on puberty blockers.** (NHS 15 Feb 2024c) **Further, as just reviewed above, the health authorities of England, Sweden, and Florida and researchers in Germany have, taken together, conducted several research reviews and found the evidence to be of uncertain quality. WPATH SOC version 8 says,**

> Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. (Coleman et al., 2022, p. S46)

m. **The members of WPATH appear to have made a statement of their own. In the one year since WPATH published version 8 of its Standards of Care, 60% of its members reportedly have dropped out.** Perhaps more information

explaining this development will be forthcoming. (Critical Therapy Antidote, 2017

138. A systematic review of gender dysphoria or gender incongruence treatment guidelines, commissioned by Dr. Cass for her final report to NHS England, found nearly all guidelines were of insufficient quality, and nearly all were based on 2 insufficient early guidelines—those of the Endocrine Society and the World Professional Association for Transgender Health.

a. Dr. Cass commissioned the University of York to conduct a systematic review of guidelines. Using the most-commonly-applied and comprehensively validated appraisals tools, the review of 23 guidelines concluded that only 2, the Swedish and Finnish guidelines, scored above 50% for rigor of development. (p. 128) The review said most provided insufficient evidence about the risks and benefits of medical interventions, "then went on to cite this same evidence to recommend medical treatments" or cited other guidelines that made these recommendations.

b. The final Cass report described the circular dependence of nearly all the guidelines. (Cass, April 2024, p. 130)

    i. Early versions of the Endocrine Society (2009) and World Professional Association for Transgender Healthcare (WPATH) version 7 guidelines "influenced nearly all the other guidelines." (p. 130)

    ii. "**9.21** These two guidelines are also closely interlinked, with WPATH adopting Endocrine Society recommendations, and acting as a co-sponsor and providing input to drafts of the Endocrine Society guideline. WPATH 8 cited many of the other national and regional guidelines to support some of its recommendations, despite these guidelines having been considerably influenced by WPATH 7…." p. 130

    iii. **"9.22** The circularity of this approach may explain why there has been an apparent consensus on key areas of practice despite the evidence being poor." p. 130)

c. **"9.23** Only the Swedish and Finnish guidelines differed by linking the lack of robust evidence about medical treatments to a recommendation that treatments should be provided under a research framework or within a research clinic." (Cass, April 2024, p. 130)

d. "**9.24** The guideline appraisal raises serious questions about the reliability of current guidelines. Most guidelines have not followed the international standards for guideline development (AGREE Next Steps Consortium, 2017). **Therefore, only the Finnish (2020) and the Swedish (2022) guidelines could be recommended for use in practice."** (p. 130, bold added)

e. The final Cass report elaborated on the WPATH guideline's failure to rely on a systematic review. It said **the WPATH version 8 standard of care "does not reference its own systematic review" and instead says a systematic review regarding treatment outcomes is not possible** due to the low number of studies. Yet the WPATH SOC version 8 stated, "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD [transgender and gender diverse] people in need of these treatments." (Coleman et al., 2023, p. S18) WPATH could have said it based its recommendations on clinical consensus since research evidence is inadequate, but instead it overstated the strength of the evidence, saying, "Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria." (Coleman et al., 2023, p. S18) (Cass, April 2024, p. 131; Taylor et al., 2024, Clinical guidelines)

139. The various versions of the MoU have yet to cite that signatories have conducted a systematic research review on affirmative gender interventions or to report a thoughtful analysis of existing systematic reviews by the National Institute for Health and Care Excellence (NICE England), the interim and final Cass reviews for NHS England, and additional government health authorities.

140. Authors and practitioners Marcus and Susan Evans report the psychological harm they have observed that has been caused by the required affirmative approach of the Tavistock Clinic and the Memorandum of Understanding. The affirmative approach has neglected to address psychological problems.

a. **Marcus Evans** is a psychoanalyst with the British Psychoanalytical Society. He worked in the NHS for 40 years and was **clinical lead of the Adult and Adolescent Departments at the Tavistock and Portman NHS Foundation Trust for several years**. **Susan Evans** is a psychoanalytic psychotherapist who worked in the National Health Service (NHS) for nearly 40 years, including the **national gender identity service (GIDS) for children**. She is a member of the British Psychotherapy Foundation and the London Psychoanalytic Psychotherapy Service and is registered with the British Psychoanalytic Council. The couple have published a book, *Gender Dysphoria, A Therapeutic Model for Working with Children, Adolescents and Young Adults* (2021b) and articles on treating gender dysphoria (Evans & Evans, 2021a; M. Evans, 2020; 2023).

b. **Here are some of the authors' passages giving insights into problems gender dysphoric young people have and an affirmative approach ignores or denies and hence neglects to address.**

i. **In contradiction to the MoU required viewpoint, Evans and Evans hypothesise that a person who has gender incongruence or gender dysphoria likely has underlying psychological problems that presumably are less favourable to feeling comfortable in one's body and identifying with one's sex.** They say,

> Our hypothesis is that the individual who feels that their body or sex is wrong is likely to be defending against psychological traumas from the past: traumas which form part of their psychic structure in the present. It is important to state here that when we use the word traumas, this can refer both to traumas which are apparent in the external world, such as physical abuse and early childhood separation or loss, and to those that are less visible but are experienced internally by the individual as traumatic, such as developing awareness of limitations of an unfavourable comparison with a sibling. (Evans & Evans, 2021b, p. 7)

ii. **Feelings of anger when grieving over sexual loss from medical interventions and over never having had a psychological evaluation of underlying causes for their gender dysphoria can lead to suicide attempts.**

> During the 1980s, I assessed adult parasuicides (apparent suicide attempts, or suicidal gestures). A number of my patients had gone through gender-reassignment surgery, and often were angry at the loss of their biological sexual functioning. They also were aggrieved with psychiatric professionals, who, they believed, had failed to adequately investigate the underlying psychological difficulties associated with gender dysphoria. (M. Evans, 2020, p. 2)

iii. **Failure of medical interventions to resolve serious mental health problems can lead to increased self-injury and suicidality.**

> As a psychotherapist, I consulted with various mental health services that managed patients exhibiting challenging behaviours. In this capacity, I observed that patients who had a history of serious and enduring mental illness or personality disorder sometimes would also develop gender dysphoria. A common theme in their presentations was the belief that physical treatments would remove or resolve aspects of themselves that caused them psychic pain. When such medical interventions failed to remove their psychological problems, the disappointment could lead to an escalation of self-harm and suicidal ideation, as resentment and hatred toward themselves was acted out in relation to their bodies. (M. Evans, 2020, p. 3)

iv. **Evans and Evans believe transition may offer avoidance of normal anxiety about sexual development, but psychotherapy can be effective in helping gender incongruent or dysphoric adolescents to enjoy what their natural sexed body has to offer.**

> We also have found that the desire to transition often is related to a wish to control sexual development, and perhaps to defer it entirely—including in a literal sense, through the use of puberty blockers. It's interesting to note that many detransitoners [sic. detransitioners] report that there is little talk about sex on pro-transition websites, or in the medical care they received. Under the current "affirmative" model of treatment (which might more aptly be called a "belief-confirmation" model), some services may be tacitly providing reassurance to young people that their anxieties about sexual development will be removed through gender transition. We would argue, however, that adolescent confusion and distress is a normal and even necessary part of development. And over time, the adolescent can be helped and supported to become an adult who might enjoy what their natal sexual body has to offer. (Evans & Evans, 2021a, pp. 7-8)

v. **Children demanding transition may wish their parents would understand them instead of supporting transition. They may be disappointed professionals were unable to stand up to their demands**.

> Moreover, in our experience, we have found that children wishing to transition subconsciously often hope that a parental figure will step in and help to identify and understand the part of the self that they are trying to discard. Some detranstionors mention, after the fact, that they were disappointed by doctors' and therapists' inability to stand up to their insistent demands for transition action. (Evans & Evans, 2021a, p. 10)

vi. **The wish to transition may be expressing grievances toward parents.**

> Most of us harbour grievances toward our parents for failing to provide us with an idealised mind, body, and/or environment. These grievances often are based on the belief that we would have been in a better position to deal with life if only our parents had not, for example, favoured our younger sibling or given us large ears. Changing the name chosen by a parent can represent an unconscious complaint against them: It is believed that the parents not only gave their child the "wrong body" but also gave them the wrong name. This can represent a wish to

> kill off the individual created by the parents, creating instead someone who has chosen their own name and their own gender. The hostility involved in grievances often is consciously denied while being communicated at an unconscious level. (Evans & Evans, 2021a, p. 12)

vii. **The path to psychological maturity and mental health requires tolerating aspects of oneself, not intolerance.**

> We take the view that people might change their name and other identifying details, but they cannot get rid of the person they were. You can perform surgery on the body, but it is a mistake to try to surgically remove a part of one's personality. Psychological maturity and mental health are based on an ability to tolerate different aspects of the personality, and intolerance does not help psychic integration. (Evans & Evans, 2021a, p. 13)

viii. **Patients may fear the idea of an underlying context to gender dysphoria. Psychotherapy, not transition, can help them understand underlying feelings.**

> …the child can feel threatened by the very idea that their actions and desires have an underlying psychological meaning…. The therapist needs to gradually draw the patient's attention to this absence of curiosity…. (Evans & Evans, 2021a, p. 14)

ii. A thorough evaluation must look at context. Affirmation neglects to do this.

> … a thorough and general therapeutic assessment …. includes an understanding of the family and social context in which the gender incongruence has emerged. (Evans & Evans, 2021a, p. 13)

iii. Children's identities develop and change over time as they mature.

> Children need help and support in coming to terms with who they are as part of the maturational process. One often hears it suggested that even toddlers possess some unchanging, soul-like "authentic self" whose actualisation eventually requires them to take puberty blockers. This conception betrays a misunderstanding of the changing nature of human development, since children's identities develop as they mature. (Evans & Evans, 2021a, p. 14)

iv. **Diagnoses made in childhood change on the path to adulthood.**

> Predictions of prognosis and outcomes based on psychiatric diagnosis in childhood and adolescence are not reliable as the young person will change as they mature. We hold that it is imperative to keep the developmental path open into adulthood and that no long term social or medical decisions should be made on the basis of a snapshot diagnosis in childhood, even if the presentation appears consistent and persistent. (Evans & Evans, 2021b, p. 8; see also Evans & Evans, 2021a, p. 9)

v. **Evans and Evans carry all these concerns, believe gender dysphoria is pathological, and value gender dysphoria resolution, but they do not impose on the patient what the outcome should be.** This is consistent with a view that therapy goals should be client-centred and developed collaboratively by client and therapist.

> The therapist should not impose a view of what the ultimate destination should be and what actions the patient should take. (Evans & Evans, 2021b, pp. 8-9)

vi. **Patients need protection from rigid affirmation.**

> Patients with gender dysphoria need services that are insulated from overzealous advocacy groups and political activists. A rigid one-size-fits-all affirmative approach is unhelpful. (Evans & Evans, 2021a, p. 15)

vii. **Evans and Evans charge the MoU with having been captured by a psychologically shallow political agenda.**

> The ‘affirmative approach’ risks sending children down a path towards concrete and sometimes irreversible medical interventions for what is in very many cases a psychological problem. This approach, in my view, is driven by political ideology rather than clinical need and inhibits the clinician’s curiosity and freedom to explore a child’s underlying belief systems and motivations. The ‘affirmation approach’ looks narrowly at a problem in only one area of psychological functioning, as if one part of the individual could be isolated from other areas of the personality, so ignoring the complex relationship between the overt symptomatic picture and trauma, social anxieties and even the relatively normal turbulence of adolescence.” (M. Evans, 2020; p. 1)

> **This Memorandum implies that there is a fixed category called 'transgender' which, like eye colour, is simply a given that need not be thought about or understood. Children's *sexual orientation and gender identity* are formed out of a complex developmental process that involves an interaction between their body, their mind and society at large. Sexual identity and gender identity are developmental processes that evolve as the individual goes through the different life stages. The Memorandum is, in my view, symptomatic of the way that *political agendas* have influenced this area of clinical practice.** (M. Evans, 2020, p. 2, bold and italics added)

141. In addition to being psychologically harmful as Evans and Evans highlight, the MoU coerced affirmative approach is multiculturally inappropriate and can be seriously distressing and harmful for people of traditional religions. For example, people who detransitioned for religious reasons have reported they cannot get help. (Vandenbussche, 2021) The MoU allows individuals support to be sterilized in order to live consistently with their gender identity but forbids support to not want to be sterilized in order to live consistently with their religious identity. Change-allowing therapy that is open to a client's goal of sexual self-acceptance is culturally appropriate for traditionally religious clients who desire to live consistently with their religion and become comfortable with their sex. This client-centred exploration should be accepted clinical practice. The Association of Christian Psychologists in Poland has developed an appropriate standard of care for this traditionally Christian population. (Marianowicz-Szczygieł et al., 2024)

142. The views of Evans and Evans, the findings of the largest ever research review on affirmative gender identity treatment conducted by Hillary Cass for NHS-England, and the positions of skeptical professional organisations demonstrate that the affirmation-only approach of the MoU does not have irrefutable scientific research support or professional consensus support that justifies the loss of freedoms that result from its viewpoint requirement.

143. The MOU only allows therapists to give people who suffer gender distress coping skills to go on living with it or risky, body-altering medical treatments that are scientifically unsupported, experimental, potentially sterilising, potentially irreversible, chronic disease producing, generally do not reduce suicidality for young people, do not improve mental health and may worsen it, and are not multiculturally appropriate. The MoU uncritically accepts these interventions but prohibits consensual therapy conversations to help a person who wants to resolve their gender dysphoria by becoming able to accept their own natural body and identify with it, at least if the client or therapist holds a viewpoint that it is preferable if a person can identify with their own body rather than reject it. There is no scientific justification for this.

IX. ETHICAL GUIDELINES SUPPORT THE SAFETY AND EFFECTIVENESS OF CHANGE-ALLOWING PSYCHOTHERAPY

144. **A fundamental ethical premise is the right to self-determination which therefore must include the right to therapeutic help to decrease distress about one's sexuality or gender identity and to engage in exploration of one's sexuality and gender that may or may not result in shaping or developing it.** (IFTCC Practice and Ethics Guideline/PEG, 2023)

145. **Ethical change-allowing therapists and counsellors follow ethical guidelines**. Therapists who are members of professional organisations that are open to a client's desire for exploratory therapy that decreases distress, improves well-being, and may or may not lead to reduction or change in sexual or gender feelings or behaviours are governed by ethical guidelines and conduct themselves in the following ways. (IFTCC Practise and Ethical Guidelines (PEG), 2023a; ATCSI Guidelines, 2017; RTA Standards, 2017)

146. **Change-allowing therapists work to reduce shame, increase self-acceptance and self-esteem, and improve supportive relationships with God and others which reduce psychological stress and help allow for changes to occur naturally.**

147. **They do *not* take a position that a client *should* change** sexual orientation or gender identity or engage in therapy to do so.

148. **Therapy for any goal is for clients who *desire* that goal**. Ethical change-allowing therapists do not attempt to persuade or coerce a client to adopt a therapy goal of change in sexuality or gender, even if another party, such as parents, spouse, or adult children, may wish the therapist to do so, the same as would be a therapist's practice in the case of any therapy goal. Where parents desire therapy for their child and the child does not desire such therapy, change-allowing therapists may offer supportive therapy for the parents or offer therapy to explore with family members, if appropriate, whether they desire assistance to support them in having the best relationship they can have.

149. **Contemporary, professional change-allowing therapy uses *nonaversive* methods.** Aversive/behaviouristic methods, such as electroshock, fell out of use in the U.S. 40 to 50 years ago. I can say as an executive board member of the International Foundation for Therapeutic and Counselling Choice that serves professionals and pastors in more than 30 nations, wherever aversive methods may be reported in some regions of the world, we strongly and unreservedly oppose them. The preamble to the IFTCC's "Practice and Ethical Guidelines Document" states, "*We emphasise that the IFTCC does not support aversive, coercive, or shaming treatments, however they are termed, and regardless of whoever applies them or wherever they are practised.*" (IFTCC, PEG, 2023) We are engaged in training professionals and pastors internationally in providing ethical care.

150. Change-allowing therapists do not believe or communicate to clients that people can change their sexual attractions just by choosing to change. Obviously, if they did believe that was so, they would not offer change-allowing therapy or counselling, because assistance would be unnecessary. It is not the case that, if same-sex attraction feelings are not biologically determined, they are simply a willed choice, because there is evidence that there are psychological influences or causes that individuals did not choose.

151. Ethical contemporary change-allowing therapists discuss with clients realistic expectations for change-allowing therapy. They do not promise or guarantee therapy outcomes. It is important to note that change, when it occurs, is usually not a categorical change from exclusively same-sex attraction to exclusively opposite-sex attraction but takes place on a continuum, as is the case for nearly every other psychological and behavioural condition for which people seek professional care. The IFTCC policy statement on "Change" (2020) says, "The IFTCC will not endorse any Member who directly or indirectly communicates to Clients that categorical change is a regular occurrence" from exclusive same-sex attraction to exclusive opposite-sex attraction. Change is more commonly partial, and some do not change. Realistic expectations are to be clearly understood by therapists and communicated to clients. A partial change may change a life, enabling some to achieve their social or religious life goals for marriage and family or abstinence.

152. Therapists plan individualised care collaboratively with clients based on the best available evidence, clinical expertise, and the client's characteristics, preferences, values, and beliefs. (Cass, April 2024, 10.74-10.75 on p. 146; APA, Professional Practice Guidelines, 2021c)

153. Therapy may provide many benefits, decrease distress, and improve psychological well-being, whether changes in sexuality or gender are partial, full, or none. Even partial change can change a life.

X. THE BEST AVAIILABLE RESEARCH SUPPORTS THAT CHANGE-ALLOWING THERAPY FOR SAME-SEX SEXUALITY IMPROVES MENTAL HEALTH AND IS EFFECTIVE

154. Claims that there is a lack of evidence that sexual attraction feelings can change through psychological intervention or that evidence proves change-allowing therapy is always, or at least usually, unsafe or ineffective are invalid. Randomized controlled trials have found decrease in same-sex partners and change in sexual attractions through psychological interventions. Longitudinal studies also have found these outcomes and increase in opposite-sex behaviour and have included assessments that found decrease in distress and improvement in psychological well-being. Additional studies have provided more detailed findings.

155. One of the most comprehensive reviews ever conducted concerning a century of research on sexual orientation change efforts, including studies published by American Psychological Association (APA) members in APA peer-reviewed journals, provides evidence that participants reported they changed their sexual

attraction and behaviour in part as a result of professional therapy assistance. (Phelan et al., 2009) Hence, on this point, two of the most comprehensive research reviews concur—one published by the professional organisation of change-allowing researchers in the United States[8] (Phelan et al., 2009), and the APA Report (2009) published by the LGB-identity-affirmative task force of the American Psychological Association. The APA Report acknowledged, "For instance, participants reporting beneficial effects in some studies perceived changes to their sexuality, such as in their sexual orientation [meaning sexual attraction in this context], gender identity, sexual behaviour, sexual orientation identity…or improving nonsexual relationships with men". (APA, 2009, p. 49)

156. **The Coventry University research review commissioned by the UK government on "conversion" therapy recommended that change-allowing therapy should be evaluated based on the best available research rather than on requiring randomized controlled trials, considered gold standard research.** (Jowett et al., 2021) These researchers said it is unlikely that randomised, controlled trials (RCTs), which it said are the "gold standard" for researching the safety and effectiveness of any therapy, could ever be applied to "conversion" therapy. Such research may be unethical, because researchers ethically cannot randomly choose which participants will receive affirmative therapy and which will receive therapy that may result in reduction or change of same-sex attraction or behaviour. It is clients themselves who must choose their therapy goals and what they want regarding their own sexual feelings and behaviours. Therefore, the research review said, decisions about safety and effectiveness must be decided by the best available research.

157. **The Jowett review was only able to look at research published as of June 2020.** As a result, the reviewers had access to a study by Blosnich and colleagues (2020) that claimed harm but not access to a reanalysis of its data that reversed its findings. (Sullins, 2022a; 2022b; 2023a; 2023b). With respect to psychotherapy for gender identity, the Jowett review had the limitation of being pre-Cass review (Cass, 2022; April 2024). The best-available research on the efficacy of change-allowing therapy includes studies published since the Jowett review or not directly within its search criteria, and I will now present these.

158. **A counterbalanced quasi-experiment found that attraction feelings reduced through psychological intervention, whether or not the feelings were likely caused by trauma, even when the fantasies were positive and enjoyable, whether fantasies were based on memory or imagination, and regardless of sexuality identity. "Sexual fantasies were reported as less vivid, positive, and arousing"** after the intervention (having to do with eye movements as in eye movement desensitization reprocessing). "There were no gender differences." (Bartels et al., 2018)

    a. Researchers did not compare outcomes by sexuality identity but said it appears the outcomes may have occurred regardless of sexuality identity.

[8] The organisation was first named the National Association for Research and Treatment of Homosexuality, currently named the Alliance for Therapeutic Choice and Scientific Integrity. (TherapeuticChoice.com)

Sexuality identity for the participants was 86% heterosexual, 5% homosexual, 7.5% bisexual, and 1% no information. (Bargels et al., 2018)

b. It is not known whether the changes would have continued at a follow-up or would continue at a follow-up conducted after additional repeated interventions over a period of time.

c. The study looked at attraction to specific sexual fantasies. It is not known from this study whether a general sexual attraction was or may be reduced by this method.

159. Psychological-intervention-mediated sexual attraction change occurred in mostly heterosexual women who did *not* have a goal of changing sexual attraction. The study was a multiple-methods, counter-balanced, randomized, controlled experiment, hence a very rigorous study. Researchers expected opposite-sex attraction to increase during mindful attention, which it did, and expected same-sex attraction also to increase during mindful attention, but it decreased, as previously presented in my report. (Dickenson & Diamond, 2018; Dickenson et al., 2020)

a. **Mostly heterosexual attracted individuals are greater in number than all other same-sex-attracted individuals combined** (bisexual, mostly homosexual, exclusively homosexual). They are second in number only to exclusively opposite-sex attracted. Some want change-allowing therapy to enhance their opposite-sex attraction side and decrease their same-sex attraction side. (Research on mostly heterosexual attraction reviewed in "V. Same Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan")

b. **Brain imaging during the experiment** evidenced different neural activity during self-reported mindful attention to opposite-sex versus same-sex attraction feelings**.** (Dickenson et al., 2020)

c. **Since some changes were in the direction opposite to researchers' expectations, and since participants presumably did not have a goal or expectation of these sexual attraction changes, it seems unlikely that researcher or participant expectations biased perceptions of them.**

d. The study did not look at whether the changes in sexual attraction continued after this experience or whether such changes would continue if a mindful attention intervention were repeated over some time. The study did not look at men or women whose sexual attraction is equally toward both sexes, more homosexual, or exclusively homosexual. The study did evidence changes in sexual attraction through psychological intervention, both decreasing same-sex attraction and increasing opposite-sex attraction.

160. A randomized, placebo-controlled experiment found that 3 psychological interventions each significantly reduced arousal, vividness, and emotionality of 2

unwanted sexually arousing memories simultaneously by the end of a 20-minute teleconference meeting with a researcher and the changes were maintained at 1 week and 4 week follow up appointments for assessment only, without further intervention. (Nicolosi & Szandula, in press for 2025)

a. The 3 interventions were (1) a hybrid feeling-state (Miller, 2012; Tsoutsa et al., 2014) and flash technique (Manfield et al., 2021), (2) guided breathing (van den Hout et al., 2011), and (3) a blink cycle (repeated deliberate blinking: Wong, 2021; Matthijssen et al., 2021; combined with a visual tracking movement: Ecker, 2018; Schubert et al., 2016; while thinking of something positive: Grol et al., 2014). All 3 interventions were found significantly to decrease arousal, vividness, and emotionality in comparison to the placebo. The researchers explained that these methods are thought to facilitate reconsolidation processes of memories.

b. Researchers said, "No adverse reactions were reported."

c. Memories that participants reported were 69% unwanted same-sex memories, 25% unwanted heterosexual memories, and 6% unwanted bisexual memories (1 same-sex and 1 opposite-sex). "Unprompted by the experimenter, several participants volunteered their motivation to participate in this research study, disclosing that it was precisely because their unwanted sexually arousing memories were inconsistent with their current sexual self-identification and overall type of sexual arousal (heterosexual, homosexual or bisexual) that they wished to participate."

d. Other motivations for participating in this study included to counter temptation to return to extra-marital sexual activities, to address attraction to underage individuals, to eliminate pleasurable associations to a trusted caregiver who subsequently abused, and to reduce sexually arousing memories no longer desired by a detransitioner.

e. The researchers said regarding recruitment of the 144 participants, "Nearly one-third of the participants found the study through the Muslim podcast, another one-third through the married Christian podcast, and the final one-third through Reddit and UCLA [University of California at Los Angeles] on-campus recruitment."

161. **Standard therapies, LGB culturally adapted standard therapy, and LGB lay peer counselling have confirmed in several sets of randomised, control trials, considered gold standard research, that men who had sex with men have significantly decreased casual same-sex partners and maintained change** at 6 months and 1 year follow up (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Reback & Shoptaw, 2014) or at 8 months from start of treatment. (Nyamathi et al., 2017) This research was conducted by LGB-identity-affirmative researchers to help men who have sex with men decrease drug use and risky sexual behaviour with the goal of reducing risk of HIV transmission. The research outcomes demonstrated that same-

sex behaviour can be effectively decreased or suppressed through therapy. LGB culturally adapted therapies were largely not more effective than standard therapies. (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Reback & Shoptaw, 2014) In the largest and most recent of these studies (Nyamathi et al., 2017, Abstract), researchers noted that men for whom same-sex behaviour was inconsistent with their values (researchers assessed their values as higher "homonegativity") and men who were fathers were especially successful in decreasing same-sex partners. These may be men who were motivated by a desire to live according to their religious or cultural values and beliefs and men who wanted to initiate, protect, or restore an opposite-sex marriage and family. Reducing same-sex behaviour may be one of the most common goals of change-allowing therapy.

162. In addition to these several randomized controlled trials, longitudinal studies also have found changes in same-sex attraction and behaviour. A study of 75 same-sex-attracted and mostly religious men, validated to have engaged in Reintegrative Therapy® (client volunteers in a Reintegrative Therapy® counseling center, study conducted by an independent researcher), found: (Pela & Sutton, 2021)

a. **Motivation for therapy to explore their sexuality was: 30% religious reasons, 37% desire to pursue a traditional marriage.**

b. All therapists were certified in **Reintegrative Therapy®,** a specific type of therapy that is applied for a *wide range* of client goals and that is protected by a trademark from the United States government[9]. Reintegrative Therapy® is not a synonym for sexual orientation change efforts (SOCE) or "conversion" therapy, as it is sometimes mistakenly represented. It uses a specific combination of evidence-based mainstream interventions for trauma and addictions that includes using EMDR or mindful self-compassion. (ReintegrativeTherapy.org).

c. **Psychological well-being improved significantly, strongly, and clinically.**

d. **The men made the following highly statistically significant changes in the modest range. The probability of these outcomes occurring by chance alone was less than 1 in 10,000 (p<.0001).**

    i. decreased *same-sex attraction* expressions.
    ii. increased *opposite-sex attraction* expressions.
    iii. changed sexual attraction *identity* in the heterosexual direction.

[9] Reintegrative Therapy®: U.S Office of Patents and Trademarks, Reg. No. 5,771,624, Registered Jun. 4, 2019 Serial #87-699,885, First use 7-1-2017, The Nicolosi Trust (California Trust). It is used for a variety of therapy goals and does not take a position on same sex sexuality. It is not specifically a change allowing therapy, but clinicians are open to a client's goal of reduction or change in same sex attraction or behaviour. Equating this trademarked therapy with "conversion therapy", "sexual orientation change efforts", or generic or other change-allowing therapy can lead to a lawsuit in the United States.

e. The researchers operationally defined same-sex attraction and opposite-sex attraction, which are subjective feelings, in terms of observable, measurable, behavioural expression of feelings to facilitate objective means of research measurement, as researchers commonly endeavour to do. It would be a mistake to infer that Reintegrative Therapists® focus primarily on behaviour. They are trauma therapists, not behaviourists. (https://www.reintegrativetherapy.com)

f. **The strengths of the research design make this study the most rigorous available research to date:** *an independent, quantitative, quasi-experimental, naturalistic, prospective, 2-year longitudinal, single group, repeated measures design (at 6, 12, 18, 24 months) employing a specific type of therapy, namely Reintegrative Therapy®, conducted by clinicians certified in that therapy, with research participants verified to be undergoing that therapy*. (Pela & Sutton, 2021) The quasi-experimental design means the researchers did not randomly assign some participants to be clients in change-allowing therapy. The study was "independent", meaning the researchers were not the therapists and were from outside of the clinic where the study was conducted. The study is "naturalistic", meaning it was conducted in a natural therapy setting rather than in a laboratory. It can be uncertain whether outcomes achieved in a laboratory will carry over to real life. "Repeated measures" means the same participants were assessed repeatedly at multiple times, as long as they were still in the therapy or study.

g. **The study has some limitations.** There was not a comparison group, for example a group treated by another method or an untreated group (such as a group placed on a wait list) to prove the changes occurred as a result of the treatment and not just as a result of the passage of time and life experience. There was not another type of measure besides self-report to support self-perceptions. Also, we do not know what accounts for cases of attrition. Since the study was being conducted in a naturalistic clinical setting, we may expect that some clients completed therapy. Lending credence to this is the finding in a longitudinal study that most benefit occurred in the first year or two (Jones & Yarhouse, 2011, p. 423) and the finding in another longitudinal study that 71% of participants achieved sexual abstinence after about 9 months (38 sessions) or more of therapy (Shaeffer et al., 1999). The same appears to have occurred here. (Peala & Sutton, 2021, Table 3) At the 12 month follow up in the present study, 71% of participants were still benefitting enough to stay in therapy. Most attrition occurred later than 12 months**.**

h. **The therapy researched in this study *does meet the criteria* for "evidence-based" therapy at this time**. The American Psychological Association identifies the components of "evidence-based practice in psychotherapy" as use of the best available research, clinical expertise, and attention to patient characteristics, culture, and preferences. (APA, 2021) This therapy is based on the best available research (which is this study and other research presented here) and uses therapists certified in the therapy modality of this study. The

therapy is fitting for the characteristics, culture, and preferences of clients who choose this therapy in this study. Most are self-identified religious men whose preference is to reduce or change same-sex attraction or behaviour to live according to their religion and/or to pursue or preserve an opposite-sex marriage. **The Reintegrative Therapy® Association takes no position on sexual orientation. It is, however, open to clients who want to decrease distress regarding unfulfilling or undesired same-sex attraction and want to explore their sexuality with openness to potential for change.**

i. **Examples of Reintegrative Therapy® may be viewed in demonstration videos on the website of the Reintegrative Therapy Association at https://www.reintegrativetherapy.com.**

163. **In a study of individuals who engaged in religiously mediated change efforts, psychosocial symptoms only improved, and the majority experienced changes in sexual attraction and behaviour. These were the findings in another independent, quantitative, quasi-experimental, naturalistic, prospective, longitudinal study. It used mixed methods, repeated follow-up assessments over 6 to 7 years, and assessment for potential harm.** "This study addresses the generic questions of whether sexual orientation is changeable and whether the attempt is harmful by focusing only on the religiously mediated approaches to change." (Jones & Yarhouse, 2012, p. 407) Some participants also engaged in professional psychotherapy. The study included both male and female participants.

a. **The researchers designed the study to meet the standards of the American Psychological Association Task Force** (2009, p. 6) on sexual orientation change efforts. They explained**,** (Jones & Yarhouse, 2011, p. 406, bold added)

> **[T] his study meets many of the standards proposed by the American Psychological Association Task Force. In particular, and responding to their five recommendations:**
>
> 1. The present study is prospective and longitudinal.
> 2. Its quasi-experimental design is adequate to address ("generalize to") the fundamental question of whether sexual orientation change is ever possible, although the design is inadequate, as the Task Force Report points out, because of the "absence of a control or comparison group" (American Psychological Association, 2009, p. 90), to allow for decisive causal attribution of the changes noted to the religious interventions. The design is adequate, however, as a test of the possibility of change.
> 3. The study used the best validated measures of sexual orientation current in the late 1990s when the design was set.
> 4. The study did not address competing explanations as proposed by the Task Force because it had an insufficient sample size to make valid inferences.
> 5. The study included a validated measure of psychological distress as an index of harm.

b. **Participants were solicited through leaders of 16 local ministries in the U.S. that were members of Exodus International, validating that participants were actually engaged in religiously mediated change efforts.** Participants were 72 men and 26 women for a total of 98 individuals. Among these, 87% attended religious services nearly weekly or more (50% weekly or nearly weekly, 37% more than weekly). Participants were highly educated, 56% having graduated from college and 27% (26.5%) having completed some graduate training. Average age was 38 (37.5) years with the youngest 21 years of age. Retention rate for all years was a favourable 64%, yielding 63 participants who completed some measures through all of the 6 to 7 years. (p. 410)

c. **Initially, participants who had been in Exodus change efforts only 1 year were solicited, but eventually participants with 3 years of experience were also included. The time the 1-year group began was designated as T1, and the time the 3-year group began was designated T2.**

d. **"The sample overall had considerable sexual experience."** The researchers reported, (Jones & Yarhouse, 2011, p. 409)

> Among the 72 male participants, only 16.7% had not had sex with another man as an adult, and one third had had sex with 30 or more other men. Approximately half of the men had never had sex with a woman, and overall, the experience of the male sample with sex with women was considerably less than their experience with male partners. Of the 25 women who gave us meaningful data, only 8% had not had sex with another woman as an adult, and the largest group, 80% of the female sample, had had sex with one to nine other women. The women were less sexually experienced with men; 28% had never had sex with a man. (Jones & Yarhouse, 2011)

e. **Among the assessments made by psychological tests, sexual attraction, emotional or romantic infatuation, and sexual fantasy—considered foundational dimensions of sexuality—were assessed** on a 5-point Kinsey scale that went from exclusively heterosexual to exclusively homosexual. In addition, heterosexual sexual attraction, heterosexual emotional attraction, homosexual sexual attraction, and homosexual emotional attraction were each assessed separately on a 5-point Shively and DeCecco Scale. (Jones & Yarhouse, 2011, p. 412)

f. **In addition to questionnaires consisting of psychological tests such as these, participants were interviewed with qualitative, open-ended questions** at the beginning of their participation (T-1 and T-2), after 3 years—this time designated as T3, and after approximately 6-7 years—this time designated as T6. Interviewers were not shown the questionnaire results, following the procedure in the highly regarded and most comprehensive study ever

conducted of sexuality in the U.S. (Laumann et al., 1994) "The interviewers were doctoral students in clinical psychology specifically trained for this study" (Jones & Yarhouse, 2011, p. 411)

g. **After 2 years of religiously mediated change experience, many participants had already achieved abstinence from same-sex behaviour and continued to be abstinent for the remaining duration of the 6 to 7 years of the study.** The researchers said they asked participants to describe the sex of people with whom they had sexual relations on a 5-point Kinsey scale, "but here omit these from presentation as many of the individuals in our population gave no response to the question in the T2 through T6 assessments because they were behaviorally celibate." (Jones & Yarhouse, 2011, p. 411)

h. **The final outcome was that 53% self-categorised as some version of success. More specifically, 23% reported substantial reductions in same-sex attraction and substantial increase in opposite-sex attraction. An additional 30% reported same-sex attraction "to be present only incidentally or in a way that does not seem to bring about distress, allowing them to live contentedly without overt sexual activity." (Tables 1 and 7 and pp. 422-423) Note that these descriptions come from the participants' own interviews and are based on qualitative evidence.** Another 16% apparently felt they benefitted enough that they were continuing the process. At the same time, 7% experienced no change, and 25% became identity confused or gay-identified. (p. 422) These "modest if significant average changes are composites of some dramatic shifts to a gay identity, but also of others who report dramatic changes away from homosexual orientation." (p. 422)

i. **Participants reported in interviews that their abstinence was achieved through decrease in same-sex attraction, not through suppression of behaviour as the MoU appears to assume. As a result, they described feeling contented in their abstinence.** The religious participants described their same-sex attraction as occurring "incidentally" and their abstinence as living "contentedly". Religious and psychotherapy approaches commonly address attractions that accompany behaviours, because participants desire to decrease both toward the same sex. **Their outcomes may contrast with the outcome of the LGB-identity-affirming randomized controlled trials that focused on education and behavioural rewards but not explicitly on attraction per se. The latter approach might help to *suppress* casual same-sex partners.**

j. **Change was sustained over time in what was effectively a several-year follow-up study.** Change occurred most commonly during the earliest years of the study (during the first year or two, p. 423), and these changes continued throughout the 6- to 7-year length of the study.

k. **The only statistically significant outcomes on measures that assessed for harm indicated improving psychological symptoms.** (p. 425) "In conclusion,

the findings of this study appear to contradict the commonly expressed view that sexual orientation is not changeable and that the attempt to change is highly likely to result in harm for those who make such an attempt." (p. 425)

l. **The APA task force report (2009) did not have access to the final outcomes of this research.** The study was reported in 2 stages—in a book in 2007 giving an interim report before the APA Report was published in 2009, and in a peer-reviewed article in 2011 that reported the final outcomes of the 6- to 7-year longitudinal study. (Jones & Yarhouse, 2007; 2011)

164. **A third longitudinal study, an earlier study of Exodus participants, found sexual attraction changes and abstinence success were associated with better mental health for these traditionally religious individuals. Participants reported increase in opposite-sex attraction and successful abstinence from same-sex behaviour through religiously mediated efforts or through a combination of religiously mediated efforts and 38 or more sessions of professional psychotherapy. This study of whether sexuality *ever* changes included both male and female participants.** Participants were attempting to change their sexual attraction and behaviour and to abstain from same-sex behaviour due to their religious beliefs. (Schaeffer et al., 1999; 2000)

a. **Researchers surveyed 248 volunteers (184 men and 64 women) who attended North American conferences of Exodus International, an umbrella organisation of religious support ministries for religious adults who experience undesired same-sex sexuality, over 3 summers from 1993 through 1995.** Participants were mostly Caucasian (91%) and college educated (average about 4 years for men and 3 years for women) with an average age of 37 years for males and 36 years for females. (Shaeffer et al., 2000, p. 63) **Of these participants, 140 (102 males and 38 females) (56% of the participants in the original survey) also participated in a 1-year follow-up survey. Of these 140, about 94% reported they were still attempting to change or had changed their sexuality, about 1% reported they were no longer trying, and about 4% were unsure whether to continue.** (Schaeffer et al., 1999, p. 333)

b. **The researchers said they did not assume their findings would be representative of all Christians attempting to change their sexuality. Rather, they wanted to study the question of whether sexuality *ever* changes** (Schaeffer et al., 2000. P. 62), and "the intent was to document the experiences of those who are trying to change their sexual orientation for religious reasons." (pp. 68-69)

c. **In the original survey, participants rated their sexual attraction feelings and sexual behaviour separately from one another and at 2 time points—as recalled at age 18 and as currently experienced**—on a 7-point Kinsey scale that went from "exclusively heterosexual", to "exclusively homosexual". Participants also rated themselves on scales that measured mental health

items, happiness, number of therapy sessions and degree of felt benefit, and most important religious reasons for wanting to change.

d. **In the 1-year follow up survey, participants again rated their sexual attraction feelings and sexual behaviour separately from each other on the same Kinsey scale. They were also asked whether they had participated in any kind of same-sex behaviour in the past year,** the number of same-sex partners during their lifetime, and questions intended to assess their religiosity, mental health, and past year history of counselling. (Schaeffer, 1999, p. 332**)**

e. **In the initial survey, "On both the feeling [attraction] and behavior scales, participants reported currently experiencing significantly more heterosexuality than they recall experiencing at age 18…. The more heterosexuality they reported experiencing, the better their self-reported mental health."** (Shaeffer et al., 2000, abstract)

    i. **Only the sexual attraction feelings scale was used as a measure of sexuality in all remaining analyses in the study "since many of the participants did not rate sexual behaviour on the Kinsey scale, because they had not engaged in homosexual sex recently."** Their religious beliefs encourage abstinence from same-sex behaviour.

    ii. **Females reported more opposite-sex attraction both at age 18 and currently.** (Schaeffer et al., 2000, Table 1 on p. 64)

    iii. **Religiously motivated and highly religiously motivated participants did not differ in sexual attraction feelings at age 18, but the *highly motivated* religious group currently experienced significantly more sexual attraction change toward the opposite sex than the *motivated* group.** (Schaeffer et al., 2000, p. 68)

    iv. **More current opposite-sex attraction for these religious individuals was associated with more positive outlook on life,** greater happiness and self-acceptance, and less tension, depression, and paranoia. (Schaefer et al., 2000, pp. 64-65)

f. **At a one-year follow-up survey, close to two-thirds, 64% overall (61% of males, 71% of females), reported success in remaining abstinent from any type of physical same-sex contact during the past year. Of those who were unsuccessful, the majority, 88%, reported they were continuing to attempt to change their sexuality, suggesting they still believed enough in the possibility of change. Factors associated with abstinence success included high religious motivation, psychotherapy for 38 sessions or more, fewer lifetime same-sex partners, increase in opposite-sex attraction over the past year, and being female.** (Shaeffer et al., 1999, p. 335)

i. **More abstinence success reported at follow-up was associated with more happiness** and self-acceptance, and less loneliness, depression, and paranoia (Shaeffer et al., 1999, p. 335)

ii. **Few females were unsuccessful at abstinence during the follow-up year.** (Schaeffer et al., 1999, p. 35) **Because few women were unsuccessful at abstinence, further analysis of behavioural success was conducted for men only.**

iii. **Among males, the behaviorally successful and unsuccessful groups did not significantly differ in level of sexual attraction at age 18 or at the time of the initial study but did significantly differ in sexual attraction at the time of the follow-up study.** While increase in heterosexual feelings from age 18 to the time of the first survey was assessed through recall and therefore may be less reliable, change between the time of the original survey and the time of the follow-up survey 1 year later was assessed in real time longitudinally and may be more reliable. (Schaeffer et al., 1999, p. 335)

iv. **Interestingly, there was a statistically non-significant trend for exclusively or mainly homosexually attracted men to be more behaviorally successful at abstinence from same-sex behaviour than mainly both-sex attracted men, suggesting that abstinence success may be achieved regardless of the initial level of same-sex sexuality.** (Schaeffer et al., 2000, p. 336)

v. **The follow-up study found that high religious motivation was associated with the abstinence success of 71% of the men (70.8%).** (Schaeffer et al., 1999, p. 334)

g. **Researchers in this Exodus study said the finding that men who were successful in same-sex behaviour abstinence experienced greater opposite-sex attraction "addresses the concern that these individuals may be sexually abstinent but still feel homosexual. Indeed at least in our male sample, successful individuals reported moving towards heterosexuality in terms of feelings as well as behavior."** (Schaeffer et al., 2000, p. 337)

h. **The finding in this Exodus study that success in behavioural abstinence was associated with increase in heterosexual attraction feelings also lends support to findings in other studies of religious men in change-allowing psychotherapy** that decreases in same-sex behaviour may be accompanied by decrease in same-sex attraction and potentially increase in opposite-sex attraction. (Pela & Sutton, 2021; Sullins & Rosik, 2022; Nicolosi, Byrd, & Potts, 2000)

i. **Number of lifetime same-sex sexual partners also was significantly associated with sexuality change, but it is unclear whether change in this case**

was attraction change or behavioural change in the form of achieving abstinence. It seems likely that attraction change would influence behaviour change, but, vice versa, the researchers appear to suggest that also a history of lower lifetime or decreased emersion in same-sex behaviour experience may make change in attraction easier for some. The researchers in this study commented, "[T]he more immersed an individual has been in the homosexual lifestyle, the more difficult reorientation will be…. [T]he longer an individual has been practicing homosexual behaviors, the lower the likelihood of successful change". They said greater emersion in a same-sex sexuality lifestyle does not necessarily mean a person cannot experience "reorientation", but there may be more of a challenge. (Schaeffer et al., 2000, p. 336)

j. **These and other research findings raise some questions. Might differences between a traditional religious identity and community versus an LGB-identity and community be factors that contribute to the contrasting research outcomes from change-allowing pastoral or professional counselling?** Might such differences for some individuals include extent of emersion in same-sex sexual experiences, motivation for change, or potential bias for perceiving or reporting preferred outcomes? Might contrasting social influences that affirm religious identity or affirm LGB identity or provide more opportunities for same- or opposite-sex partners also be at play?

165. Longitudinal research findings—that less same-sex behaviour experience (Schaeffer et al., 2000; Schaeffer et al., 1999) **and satisfying opposite-sex relationship experience (for those who feel they have a choice in the sex with which they have a relationship) may help facilitate increase in opposite-sex attraction and decrease in same-sex attraction** (Diamond, 2008, pp. 114-118; Diamond, 2014, Ch. 20, in *APA Handbook, vol. 1;* Pomeroy, 1972, pp. 76-77)—**suggest that living according to religious beliefs may be a factor for some in outcomes of change-allowing psychotherapy or religiously-mediated change. There may be a fit between religious psychological personality formation and religious culturally adapted, change-allowing support groups, pastoral counselling, or psychotherapy.**

166. There may be a pattern that most change takes place in the first year or two of change-allowing therapy, and that psychotherapy is more likely to continue longer if there are co-occurring mental health difficulties that make treatment more complex. Research on change-allowing psychotherapy should ideally validate that there was participation in such psychotherapy and should assess the number of sessions to ascertain whether there was a meaningful exposure to change-allowing therapy.

a. **In the Schaeffer et al. study, most participants who reported they had engaged in change-allowing therapy had not had a meaningful number of sessions for therapy to be effective, perhaps especially given the state of the art of psychotherapy as practiced generally and of change-allowing therapy specifically in the 20st century**. Today, it may be that some change could begin to occur earlier depending on the complexity of the client's presenting

concerns and the skill, experience, and confidence of the therapist. (Joseph Nicolosi, Jr., personal email communication, 5 November 2024)

b. **Participants who self-reported they consulted with a psychotherapist at least once for change-allowing therapy reported on average that they actually attended a limited number of sessions**—an average of only 15 sessions at some time in their life for all participants in the original conference survey and an average of only 10 sessions in the past year for all participants in the follow-up survey.

c. **Sufficient initial sessions are needed to conduct an evaluation** of individual client needs and to identify appropriate therapy goals, to introduce the therapy so the client can decide if the therapy is what they want, and to allow the client to get a sense of the therapist and whether they would like to work with that person. A decision is made as to whether to proceed with the therapy. **A person who has had a small number of sessions has not necessarily had therapy.**

d. **Premature termination without a sufficient course of therapy may itself have risks.** Generally, in the course of any psychotherapy for a variety of possible concerns or goals, not only for change-allowing therapy, painful feelings may come to awareness, and if the person leaves therapy prematurely with such feelings left opened up and as yet untreated, the person may feel worse or perceive they have been harmed.

e. **A course of therapy of reasonable length generally was successful for achieving abstinence. The only outcome assessed in this study for psychotherapy was abstinence from any form of same-sex behaviour. Abstinence success was associated with better mental health for this religious population.** Among those who reported engagement in psychotherapy, 25% (those who "exceeded the third quartile" in the follow-up survey) reported they attended 38 sessions or more (about 9 months or more if they attended once per week), and 71% of these reported they successfully achieved abstinence. This study cannot tell us what the rate of change may have been for those who may have continued past the year between the surveys. (Schaeffer et al., 1999, p. 336)

f. **It may be that those who sought psychotherapy in addition to the religiously mediated path were the harder cases.** Overall, abstinence was 56% for all who were in therapy the year between the surveys, so the majority did change same-sex behaviour in the direction they desired. For those who had fewer than 38 sessions, 44% experienced this change in comparison to those who had 38 sessions or more, for whom 71% changed. That individuals with less therapy had a lower rate of change (44%) than people with no therapy (71% for participants on the religious path only with no therapy) implies either that therapy itself decreased change, which is unlikely in that more therapy was associated with more change, or those who needed therapy began at a

disadvantage for some reason and may have sought therapeutic assistance for that reason. For example, those who would meet ICD-11 diagnostic criteria for sexual compulsive behaviour disorder, who could not control sexual behaviour, may have sought professional assistance. (Jospeh Nicolosi, Jr., personal email communication, 5 Nov. 2024) This could account for their lower abstinence success during early sessions and catching up by 9 months or more to those who followed the religious path only. It may be that, overall, change-allowing therapy treats harder cases. There is some evidence for this in a nationally representative study of LGB-identified SOCE alumni that found those who sought SOCE had experienced "higher lifetime and current minority stress, greater childhood adversity, and lower socioeconomic status". (Sullins, 2022a, abstract)

g. **High motivation may be a factor in change, though not necessarily the only or sufficient factor. Individuals who do not change should not be told that if they had had more motivation, they would have changed.** For both participants with high religious motivation and participants who engaged in 38 or more sessions of psychotherapy, 71% reported successful abstinence during the previous year. Not everyone changed. It certainly should not be assumed that everyone who has high motivation will experience change or that, if someone does not change, they did not have enough motivation.

h. **In the Schaeffer et al. survey, we are unable to compare length of engagement in the religious path that was associated with change to length of psychotherapy that resulted in change.** For those who engaged solely in a religiously mediated change path, most had accomplished most of their change before the initial survey of this study. Attendees at Exodus conferences may have been engaged with the change effort over years, the article explains. In the year between the initial and the follow-up surveys, participants were not very active in community groups which may mean they had already experienced change.

i. **Additional longitudinal studies of sexuality change efforts also suggest that most change in both religiously mediated and professional psychotherapy paths occurred in the first year or two, but change can continue over a longer period for some. Without documentation of length of therapy, we do not know whether meaningful experience is actually being studied in research claiming harm.** In the Jones & Yarhouse longitudinal study (2011) of religiously mediated change, most change occurred in the first 1 to 2 years, although more participants had reported change by the end of the 6-to-7-year study. The Pela & Sutton (2021) Reintegrative therapy® longitudinal study included only individuals who continued therapy through at least a 6-month follow up evaluation. Most participants, 71%, continued therapy through the 12-month follow-up, 37%, continued therapy through the 18-month follow-up, and 29% continued therapy through the 24-month follow-up. (Table 3) Participants who may have continued for only 10 or 15 sessions, as was the average in the

Schaeffer surveys, were not included in the Pela & Sutton or Jones & Yarhouse studies.

j. **The Schaeffer et al. (2001) longitudinal study lends support to other studies that have found psychological well-being improved in professional change-allowing therapy or religiously mediated interventions, and some people reported they experienced changes in undesired sexual feelings and behaviours through religious and professional assistance.**

k. **This study also has limitations. The number of participants was proportionately small compared to the total number of people who attended Exodus conferences, and participants were self-selected volunteers, therefore may not have been representative of all people who attended. The small majority of initial participants who continued on to be in the follow-up study may not have been representative of participants in the initial study or of all attendees at Exodus conferences. Generalizations cannot be drawn beyond the sample of conference attendees studied. The circumstance of participants being solicited during an Exodus conference may have increased risk of response bias. Part of the initial survey relied on recall of experiences at age 18 that may have been many years prior, and recall may not have been reliable. Some data, however, were collected in real time in the original and follow-up surveys. Nevertheless, due to limitations in the study, inferences of causation should be made with caution, and findings may not be generalisable beyond the participants in this study.**

167. **Besides randomized controlled trials and longitudinal studies, additional studies provide some more detailed information. Another study specifically *assessed for both psychosocial safety and harm* in addition to sexuality changes in mostly religious men. It reported depression, self-esteem, and suicidality all changed in the improved direction. Most men significantly changed at least some aspects of attraction, identity, or behaviour in the direction they desired. (Sullins & Rosik, 2024)**

a. In a study I previously mentioned only briefly, participants were 125 men in the U.S. who experienced sexual orientation change efforts (SOCE) in the forms of professional change-allowing therapy, retreats, and/or support groups. The clear majority, 88%, attended religious services at least once per week (p. 6).

b. **Many, 41%, were married, most of these with children—on average 3 children each. The percent of married men who engaged in same-sex behaviour before SOCE was 71% and plunged to 14% after SOCE. What this means for the lives of these men, their wives, and their children can hardly be expressed. Married men experienced the greatest reduction in same-sex attraction, identity, and behaviour.** (pp. 7-8)

c. **Even men who had not completed SOCE had experienced change.** Men who had completed SOCE and men who were continuing SOCE at the time of the

survey had reduced same-sex sexuality the same amount on all 3 dimensions of sexuality—attraction (1.6 points on a Kinsey scale), identity (1.2- 1.3), and behaviour (.9), but the men who were continuing in SOCE had greater same-sex sexuality at the beginning of SOCE and therefore also at the time of the survey, hence were continuing SOCE. It was not the case that they had not experienced any change. (p. 8)

d. **"A substantial proportion of participants reported achieving some reduction, either partial or full, of unwanted same-sex attraction (69%), identification (54%) and/or behaviour (45%)."** (p. 7). About 19% of the men achieved full remission of same-sex attraction and/or identity, and 37% of the full sample of men completely desisted from same-sex sexual activity. (abstract) It is possible some single individuals may not have been engaging in same-sex behaviour at the beginning due to strongly held religious beliefs, hence did not decrease it, and those who were married may have continued their engagement in opposite-sex sexual behaviour with their spouse, hence did not increase it. Some achieved no effect on some measures (27% to 47%). Some experienced an increase in the direction toward same-sex sexual attraction (4%), identity (10%) or behaviour (8%). (p. 7 and Table 3)

e. **"Net change was significantly positive for all problem domains."** Depression decreased for 72% of the men, and self-esteem increased for 94%. Nine times more men reported a decrease in suicidal thoughts or attempts (22%) than reported an increase (2%). Only 1% to 5% reported marked or severe negative effects from the therapy, while 12% to 61% reported marked or severe positive psychosocial effects. Hence, benefits greatly outweighed any harms.

f. **Overall, in this research sample, participants safely experienced significant change in sexual attraction, behaviour, and identity in the direction they desired.** (abstract)

g. While the retrospective reports of these men cannot be generalised beyond this convenience sample, this research does report evidence of safe and effective change in individuals engaged in therapy that is open to an outcome of sexuality change. (Sullins & Rosik, 2024; this was an independent re-analysis of a publicly available data set of mostly religious men who reported experiencing change-allowing therapy.)

168. A further analysis (Sullins, 2024) from the same data set that had been used by Sullins & Rosik (2024) of religious men explored what it is that changes in change-allowing therapy. The researcher found that opposite-sex attraction increases modestly, same-sex attraction decreases more, and same-sex behaviour virtually ceases for those who transition to opposite-sex attraction that is equal to or greater than same-sex attraction. (Sullins, 2024) A much larger number of participants would be required to study how much opposite-sex behaviour changes. This study focused on only the 72 men who had completed their therapy (58% of the 125 men in the full

data set), since the outcome for those who had not completed therapy was as yet unknown.

a. **Similarly to outcomes found for the full data set, 72% of the men experienced a shift in sexual attraction in the heterosexual direction,** 6% changed sexual attraction in the same-sex direction, and 22% reported no change in sexual attraction. **The percent of men who reported their opposite-sex attraction was equal to or greater than their same-sex attraction was 11% at the start of therapy and 56% after therapy for a 45% increase.**

b. **Put another way, 45% of the men who had therapy changed their sexual attraction from mostly or exclusively same-sex attraction to equal or greater attraction to the opposite sex. How does the degree of sexual attraction change in this study** (Sullins, 2024) **compare with the degree of sexual attraction change that occurs through mere passage of time and life experience?** This therapy study did not include a comparison group, for example of people who had no therapy, that could answer this question. As a thought experiment, however, we may **consider a comparison to a U. S. nationally representative study** (Savin-Williams, Joyner, & Rieger, 2012, Figure 1) in which, over a period of 6-years, 9% of mostly or exclusively same-sex attracted men (about 1 out of 12 men, Figure 1, caption says mostly and exclusively homosexual men were combined) came to report **opposite-sex attraction that was equal to or greater than their same-sex attraction** through the passage of time and life experience. **In comparison, 5 times more men changed with therapy than with only the passage of time and life experience. This national comparison sample was younger (ages 26 to 32 years) than the Sullins 2024 therapy sample (61% ages 36 to 66+ years, Table 1). If we were to expect there would be somewhat more change in younger men than older men, the estimate that these men in the older therapy sample changed 500% more than men in the younger nationally representative sample would be all-the-more striking.** This comparison has limitations, however, for example that the participants in the therapy study were not from a nationally representative study and, also, may not be representative of men who experience change exploring therapy for sexual attraction and behaviour. Therefore, the thought experiment suggests but is unable to tell us with certainty that increase in opposite-sex attraction through therapy for the men in this study increased markedly more than would have occurred through only the passage of time and life experience.

c. **Among the 63 men who began therapy in the categories labeled as "homosexual", both the 23 men who transitioned to the "heterosexual" categories and the 31 men who remained within the "homosexual" categories experienced that the measures of same-sex sexual attraction—fantasies and desire—dropped, and heterosexual measures increased, but these changes were large and statistically significant for transitioners and small for non-transitioners.** Categories of attraction that were labeled along a 7-point Kinsey scale at the beginning of therapy as "heterosexual," "almost

entirely heterosexual," "more heterosexual than homosexual," and "bi-sexual" all gained cases after therapy, and categories labeled "more homosexual than heterosexual," "almost entirely homosexual," and "homosexual" all lost cases. Among the 63 men who began therapy in the categories labeled as homosexual, 23 transitioned to heterosexual categories, 9 transitioned to the bisexual category, and 31 experienced a shift toward heterosexuality but were still within the homosexual categories. Even a partial change for men whose sexual attraction is still more homosexual than heterosexual may be valued by those whose therapy goal is abstinence or faithfulness in an opposite sex marriage with a family.

d. **At the extreme ends of sexual attraction, however, change away from "almost entirely" or "exclusively" same-sex attraction was twice as prevalent as change to "almost entirely" or "exclusively" opposite-sex attraction**. This suggests that decrease in same-sex attraction is greater than increase in opposite-sex attraction in change-allowing therapy.

e. **In this change-allowing therapy study, increases in opposite-sex attraction were more than 2 (2.3) steps along the 7-point Kinsey scale**, somewhat larger than the changes of 1 step along a 5-point Kinsey scale that commonly occurred through life experience over the 6 years of the U.S. representative study (Savin-Williams, Joyner, & Rieger, 2012) just mentioned above when discussing the Sullins & Rosik (2024) study and mentioned elsewhere in my report. Change-allowing therapy generally extends over a much shorter time than the 6 years in the nationally representative study of change through life experience, and it allows an individual actively to initiate getting assistance for desired change rather than only being able to wait passively to see if change may happen to occur through life experience. Again, partial change may be sufficient to enable a person to achieve a goal of being abstinent or in an opposite-sex marriage.

f. **Same-sex behaviour successfully decreased to the greatest extent possible,** likely as a result of the strongly held religious beliefs of these men. "Strikingly, all 23 men in the heterosexual transition group reported almost never engaging in homosexual kissing or homosexual sex after SOCE [sexual orientation change efforts]…. For the men in the heterosexual transition group, undergoing SOCE was associated with some reduction in homosexual attraction, a smaller increase in heterosexual attraction, little or no increase in heterosexual sex behaviors but a definitive rejection of homosexual sex behaviors." (Sullins, 2024, p. 11) Given that the strong religious beliefs of the men in this study permitted opposite-sex behaviour only in opposite-sex marriage, it might be expected that change in opposite-sex sexual behaviour would be limited except for men who had a change of marital status during the course of therapy. A meaningful assessment of sexual behaviour change would require many more participants in order to compare large enough groups of men who got married, separated, were persistently single, or were persistently married during the course of therapy. Strongly religious men who

seek change-allowing therapy may experience satisfaction in decreasing same-sex behaviour even if opposite-sex behaviour does not increase.

g. **The author of this study included a discussion section on the biased denial that change such as was found in this study occurs and the persistent efforts to try to get research such as this censored.** He said, (Sullins, 2024)

> Notwithstanding this evidence, self-report data on homosexual to heterosexual change like the present is widely rejected on the speculation that persons undergoing SOCE "may be especially susceptible to believing and reporting that therapy has succeeded regardless of its true effectiveness". In all cases that I know, this suspicion is offered with no supporting evidence and is noticeably absent when considering similar self-reports of heterosexual to homosexual change ("coming out"). Proponents of this argument ignore the fact that samples that include only LGB-identified respondents almost universally report an absence of change from SOCE, whereas samples in which respondents are not screened for LGB identity, like the present one, generally report modest, mostly partial, change in sexual orientation. To my knowledge, none have offered any rationale why those who report an extreme lack of change should be believed but those who report moderate change should not be believed. Because this bias has been used not only to challenge but also to censor the publication of evidence such as the present data, and even to criminalize the kind of therapy it examines, the issue merits extended treatment in this section." (Sullins, 2024, p. 11)

h. **Regarding attempts to censor studies such as this one based on claims that same-sex sexuality is inborn, unchangeable, and who a person (ontologically) is, the author said,**

> **"Because immutability is a universal claim and grounds ontological arguments, evidence that even a few persons have credibly undergone homosexual to heterosexual change can threaten the legal and political construction of LGBT identity. For such reasons, evidence of change such as that presented in this study has been aggressively denounced and even retracted on dubious grounds in some scientific settings."** (Sullins, 2024, p. 12, bold added)

i. **A descriptive survey study of 117 dissatisfied same-sex-attracted men who indicated experience in sexual orientation change efforts reported that, on average, depression, suicidality, and self-injuring behaviour decreased, and self-esteem and social function improved. Also reported were a significant and large decrease in sexual attraction feelings and behaviour toward men and a significant and large increase in sexual attraction feelings and behaviour toward women. Married men reported significantly greater decrease in sexual feelings and behaviour toward men than did single men,**

and this finding was a moderate-sized effect. The purpose of the study was to explore characteristics of men associated with change through change-allowing psychotherapy, motivations for such therapy, and interventions and techniques the men found most helpful. (Kartan & Wade, 2010, pp. 93-94)

j. Participants were solicited from psychotherapists who offer change-allowing psychotherapy and through organisations that support these therapists or provide religious support for men who desire such change. The men in this study were on average 40 years of age (range 19-82), 86% Caucasian, 96% religious. Of these men, 42% were married and 9% were engaged, divorced, or separated while 42% had children.

k. The "markedly or extremely important" reasons most commonly given for engaging in sexual orientation change efforts were "conflict between my religion (God) and my homosexuality" for 88% of the men and "belief that the gay lifestyle was not emotionally satisfying" for 86%. The least endorsed reason was "disapproval of homosexuality by my parents or siblings" chosen by 34%.

l. On average, there was a positive change in psychological functioning, greatest for self-esteem, social functioning, depression, self-harmful behaviour, and suicidal thoughts and attempts. The least positive change was in alcohol and substance abuse.

m. "Participants perceived the most helpful sexuality change interventions to be a men's weekend/retreat, a psychologist, and a mentoring relationship, and the two most helpful techniques to be understanding better the causes one's homosexuality and one's emotional needs and issues and developing nonsexual relationships with same-sex peers, mentors, family members, and friends." (Karten & Wade, 2010, Abstract)

n. "The study findings suggest that some men who are dissatisfied with their same-sex attraction feel disconnected from other men, and feel they benefit from developing non-sexual affectionate relationships with other men." (Karten & Wade, 2010, p. 99)

o. Unexpected findings were that "intrinsic religiosity", defined as religious sentiment where the person's approach to religion is open-minded, having the ability to maintain links between inconsistencies, was associated with not reducing homosexual feelings and behaviour. Also, the more "identity" was "heterosexual", the less there was change in feelings and behaviour toward women and men. It may be that these characteristics are associated with less motivation for change.

p. Limitations of this study are that it relied on self-report—in some cases self-report based on memory that may not be reliable, may have been subject to social desirability (as is the case in studies that use self-report generally

including studies of change-allowing therapy and studies of LGB-identity-affirming therapy), used some measures that had not had validating research, mixed sexual attraction feelings and behaviours in the same measurement scale rather than measuring these separately, did not have a comparison group, included less than 10% of racial/ethnic minorities, and used methods that could find associations but not causation. Therefore, cause cannot be inferred, and generalizations cannot be made beyond these participants.

169. **Rates of change in these studies are generally consistent with historical findings**. In a 1994 survey of semi-randomly selected members of the American Psychoanalytic Association tilted to include more analysts who had a national reputation and who had published and women, 285 psychiatrists (68% of those surveyed) reported that 23% of the 1,215 homosexual patients they had treated "changed to heterosexuality", and 84% evidenced "significant therapeutic benefit". (MacIntosh, 1994; Nicolosi, Byrd, & Potts, 2000)

170. **Clients who feel they benefitted from change-allowing therapy for sexuality say they experienced the following changes in quantitative and qualitative analyses:** (Sullins & Rosik, 2024; Karten & Wade, 2010; Byrd et al., 2008; Nicolosi, Byrd, & Potts, 2000; Schaeffer et al., 2000; Schaeffer et al., 1999):

Decreased: Depression
Decreased: Tension
Decreased: Loneliness
Decreased: Paranoia
Decreased: Shame, guilt, self-condemnation, unworthiness
Decreased: Discomfort with expressions of affection between men
Decreased: Thoughts and attempts of suicide
Decreased: Self harmful behaviour
Decreased: Same-sex attraction
Decreased: Same-sex behaviour
Decreased: Same-sex passionate kissing
Decreased: Frequency and intensity of homosexual thoughts
Decreased: Desire for romantic, emotional same-sex intimacy

Increased: Feeling accepted and loved
Increased: Self-acceptance, Self-understanding, and Self-esteem
Increased: Personal power, Emotional stability
Increased: Experience of God's love, acceptance, and forgiveness
Increased: Spirituality
Increased: Healthier, more satisfying relationships and social functioning
Increased: Relationships with church, God, and family
Increased: Feelings of femininity in females
Increased: Feelings of masculinity in males
Increased: Trust in the opposite sex
Increased: Interest in opposite-sex dating
Increased: Opposite-sex attraction

Increased: Opposite-sex behaviour
Increased: Opposite-sex passionate kissing
Increased: Opposite-sex thoughts
Increased: Feeling more intimate—physically and emotionally—with their opposite-sex spouse
Increased: Desire for opposite-sex romantic, emotional intimacy

171. Research summary on change-allowing therapy with mostly religious clients:

a. **Psychological improvement in well-being generally outweighed any harms. Research that found this included 3 longitudinal studies and additional research. This finding will also be seen in a reanalysis of the leading study of LGB-identified people that claimed harm.** (More research discussion on this point at "XIII. Research That Claims Change-Allowing Therapy Is Harmful is Fatally Flawed")

b. **Research results from therapy that is culturally sensitive for LGB-identity and culturally sensitive for traditional religion converge on the finding that same-sex *behaviour* or partners can successfully and safely be reduced through therapy. This is one of the most common therapy goals and most successful outcomes of change-allowing therapy. No harm was reported for men who had sex with men who reduced same-sex partners through therapy.** This report has presented 4 randomized control trials for men who had sex with men, considered gold standard research (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Nyamathi et al., 2017), 3 longitudinal studies primarily for people of traditional religion (Pela & Sutton, 2021; Jones & Yarhouse, 2011; Schaeffer et al., 2000; Schaeffer et al., 1999), and additional studies (Sullins & Rosik, 2024; Sullins, 2024; Karten & Wade, 2010; Nicolosi, Byrd, & Potts, 2000). These support the success and safety of LGB-identity-affirmative or traditional-religion-affirmative professional psychotherapy or religious mediation for this goal and outcome. Reasons for this therapy goal include to protect health (to reduce risk of HIV transmission), to establish or protect an opposite-sex marriage and family, and to live consistently with one's religion. LGB-identity affirming therapy has found that men for whom same-sex behaviour was not consistent with their values that may be religious or cultural values and fathers were especially successful at reducing same-sex sexual partners. (Nyamathi et al., 2017, values assessed by LGB-affirming researchers as "higher homonegativity") Similarly, traditional-religion-affirming therapy has found that married men, most of whom were fathers, were especially successful at reducing same-sex behaviour. (Sullins & Rosik, 2024; Karten & Wade, 2010.) In 3 randomised controlled trials, therapy that was culturally sensitive for LGB-identity was not more effective than standard therapies.

c. **Research on change-allowing therapy has also assessed for and found reductions in same-sex *attraction* and/or increases in opposite-sex *attraction* that have accompanied and supported decreases in same-sex**

behaviour. Some participants increased opposite-sex attraction sufficiently to be in an opposite-sex marriage more enjoyably and comfortably. Participants in studies of largely traditionally religious individuals who became sexually abstinent often reported they experienced sexual attraction changes sufficient to result in *comfortable* abstinence. That is, they felt their sexual expression was changed, rather than suppressed as the MoU appears to assume. Religion-affirming studies addressed sexual attraction as well as behaviour, while LGB-identity affirming studies addressed only behaviour. We do not know from the LGB-identity-affirming therapies whether participants experienced some accompanying change in attractions or whether they felt they became better able to suppress same-sex expression. Interventions that address attraction as well as behaviour may be more effective in changing behaviour, as behaviours and attraction to engage in them are inextricably linked. Lacking clarity, does the MoU forbid therapies that may reduce (the MoU says "suppress") same-sex sexual expression or attraction or increase opposite-sex attraction or expression *ever* or *only if it is based on a viewpoint, perhaps particularly a religious viewpoint*?

d. **It would be absurd to forbid therapy that protects psychological well-being, health, marriages, and families. It would be discriminatory to allow culturally sensitive therapy with these benefits for LGB-identified people but forbid culturally sensitive therapy with these benefits for traditionally religious identified people based on a viewpoint. Forbidding therapy that may have these outcomes is scientifically unjustified and potentially dangerous. The MoU does not have incontrovertible evidence to justify taking away clients' freedoms and rights and help to leave undesired sexual behaviour or feelings, to explore potential to enhance their heterosexual side, and to live the life they desire—being comfortably sexually abstinent or in a potentially procreative marriage with family.**

XI. EMERGING RESEARCH SUPPORTS THE SAFETY AND EFFECTIVENESS OF INCREASINGLY NEEDED CHANGE-ALLOWING PSYCHOTHERAPY FOR GENDER DYSPHORIA

172. **There is an ongoing and growing need for professional therapy and counselling for resolving gender dysphoria—the distress some people feel about their sex—that may or may not also result in changing a person's perception of their gender identity and in experiencing contentedness with their innate sex. Not all gender dysphoric therapy clients have such a therapy outcome goal, but some do. The MoU forbids a client to have a therapy *goal* of this outcome, at least if there is an unapproved *viewpoint*** that identifying with one's natural sex is preferable to feeling in conflict or disharmony with it.

a. **As national health advisory bodies and/or professional organisations in England, Sweden, and Finland are increasing their emphasis on or are prioritising psychotherapy treatment for gender dysphoria, the need for professionals trained to provide it will certainly increase.**

b. **The final Cass report says, "Non-medical interventions must be developed for the care of children and young people who do not receive medical interventions."** (Cass, April 2024, p. 157)

c. **Some clients want an alternative to discordant-gender-identity-affirmative interventions to resolve their gender dysphoria and may not know where to find it**. Some detransitioners have said they wish they had had such treatment. (Exposito-Campos, 2021; Vandenbussche, 2021)

d. **There can be many reasons clients may have a desire to become comfortable with their sex, and the right to client autonomy should assure they may choose this therapy goal.** The right to choose psychotherapy to become more contented in one's body has been supported by Kenneth Zucker and colleagues. (Zucker, Lawrence, & Kreukels, 2016, pp. 237-238) Zucker was the chair from 2007 to 2013 of the work group on sexual and gender identity disorders for the American Psychiatric Association's official diagnostic manual, fifth edition, and is the editor-in-chief of the prestigious journal, *Archives of Sexual Behavior* (2002 to the present). (https://www.kenzuckerphd.com/professional) Zucker and colleagues reported the following factors in some people wanting psychotherapy to help them become contented in their body.

    i. **Desires to preserve one's marriage and family may be goals that hold a higher priority than discordant gender identity.**

    ii. **Psychotherapy may be preferable for clients whose characteristics have been predictive of less satisfaction from "sex reassignment surgery", such as more psychopathology, physical characteristics that do not go with the desired sex appearance (hence poor prognosis for "passing" and for satisfaction with the new sex appearance), adult late-onset gender dysphoria, and non-homosexual orientation**. These previously were exclusionary characteristics for sex surgery, but today, people with these characteristics increasingly request and undergo sex surgery. "These issues assume greater importance in light of recent evidence that sex reassignment is associated with more serious psychological sequelae and more prevalent regret than had previously been supposed." (Zucker, Lawrence, & Kreukels, 2016, p. 237)

e. **Some clients may want therapy that is culturally sensitive or adapted for their religious character, values, beliefs, and preference to decrease their gender distress and increase their comfort with their natural sex. Some therapists are expressing a need for therapist training to provide psychotherapy appropriate for the preferences, values, and religious beliefs of these clients.** (iftcc.org**)**

i. The dichotomising of treatment approaches for gender dysphoria into either affirmative interventions or "conversion" therapy is too restrictive and forecloses consideration of other options, in particular exploratory therapy (Ayad, 2022; Spiliadis, 2019) that explores the broad context in which gender dysphoria developed and the meaning of the gender dysphoria. Culturally sensitive and appropriate therapy for religious clients may also explore gender identity through a wide and multidisciplinary lens that also includes the client's religious character, preferences, beliefs, and values. This may be thought of as exploratory therapy that is culturally sensitive. It should not be stigmatised as "conversion" therapy.

ii. **The final Cass report says an individualized care plan should be "based both on evidence and the individual's "preferences, beliefs and values".** (Cass, April 2024, pp. 145-146, bold added) The person's individual preferences, beliefs and values may be religious and aim to resolve the core gender dysphoria to become comfortable identifying with their natural sex.

iii. **Evidence of the importance of religiously sensitive care may be seen in a guideline and standard of care for gender dysphoria that is culturally appropriate for many traditionally Christian patients and has been published by the Association of Christian Psychologists in Poland**, an association of professionals who do take into account religious beliefs and values. (in Polish or English: Marianowicz-Szczygieł et al., 2024)

iv. **A training video for Christian therapists on treating gender dysphoria in children and adolescents features two of the world's leading experts on gender dysphoria treatment, Drs. Kenneth J. Zucker and Susan J. Bradley.** In addition, several people who were gender dysphoric in childhood share their experiences. The final section of the video presents a Christian worldview, demonstrating how a relationship with God impacts Christian clients who are affected by gender dysphoria. (Hamilton, 2025, Counseling Gender-Dysphoric Children and Teenagers)

173. Detransitioners are a growing client population that will increase demand for psychotherapy to resolve continuing gender distress.

a. **Research indicates the number of detransitioners is growing.** While still reported as "rare" by the gender medicine establishment (Coleman et al., 2022; McNamara et al., 2022), the rate of medical detransition is already 10%-30% following transition as previously discussed. (Examples: Hall et al., 2021; Roberts et al., 2022; Zucker, Lawrence, & Kreukels, 2016**).** These numbers are likely to rise in the future as regret historically has taken over a decade to materialise and can take longer. (Dhejne et al., 2014, pp. 1540-1541, 75 to 177

months to regret or about 6 to 15 years) Not all of those who detransitioned will consider themselves harmed, but many will, and a number already have (Vandenbussche, 2021; Littman, 2021).

b. **Some detransitioners have reported they still had gender dysphoria after body-harming interventions failed to relieve it, and they wanted psychotherapy to help them explore and resolve it.** The final Cass report says, "Furthermore, after masculinising/feminising hormones, dysphoria may still persist. Therefore, it is important to explore other approaches for addressing the gender-related distress, which in itself is debilitating." (Cass, April 2024, p. 155)

c. **Detransitioners have said transition only delayed facing what was beneath their gender dysphoria and desire to transition.** (Vandenbussche, 2021)

d. **Treating detransitioners may be life-saving.** Former professionals of 40 years at the Tavistock clinic said, "One possible explanation for suicides or increased suicidality associated with or following gender 'affirming' interventions is that, when gender interventions fail to remove psychological problems in gender dysphoric people, the disappointment may lead to an increase in suicidal ideation or suicides." (Evans & Evans, 2021b, p. 3)

e. **Detransitioners have reported they can't find therapists to help them.**

    i. **Detransitioners have said they could not find any therapists who were trained** in how to help them explore underlying mental health problems to resolve their gender dysphoria. Some detransitioners reported therapists were afraid of them and afraid that if they tried to provide this kind of exploratory therapy, it would be taken for conversion therapy. (Vandenbussche, 2021)

    ii. **Therapists have reported during the NHS-England Cass review of treatment for transgender minors that they have been afraid to offer gender dysphoric minors the same kind of psychological care they usually offer** distressed children due to pressure to affirm discordant gender identities. (Cass, 2022, p. 48; April 2024, pp. 202, 9) Under the MoU, therapists will be afraid to help detransitioners who want to become able to accept their sex and identify with it fully for fear of being accused of conducting "conversion" therapy. (Exposito-Campos, 2021, p. 274)

f. **The Cass review recommends provision for detransitioners.** (Cass, April 2024, Recommendation 25, p. 43)

> Recommendation 25:
> NHS England should ensure there is provision for people considering detransition, recognising that they may not wish to

reengage with the services whose care they were previously under.

g. **The World Professional Association for Transgender Health (WPATH) in its latest version of its "Standards of Care" now addresses detransitioners and says they should be supported,** though it maintains detransitioning is rare, and it does not address psychotherapy some want in order to address underlying psychiatric causes to resolve gender incongruence or dysphoria. (Coleman et al., 2022, recommendation 5.7 on p. S32, Statement 5.7 on pp. S41-S42) The "Guidelines" of the Endocrine Society (Hembree et al., 2017) and the "Principles to Guide and Direct" of the American Academy of Pediatrics (Rafferty et al., 2018) do not address care for detransitioners.

174. Some gender dysphoric people have significant psychiatric disorders that cause them to be incapable of consenting to physical interventions. Even the WPATH Standards of Care recommends psychotherapy at least to treat the disorders first. It says, "We recommend mental health professionals address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated." (Coleman, et al., 2022, Statement 18.1 on p. S172)

175. Ethically, gender dysphoric patients should be advised of treatment options. Solely offering discordant-gender-identity-affirmative interventions and not warning of their risks or offering alternative treatment options is resulting in lawsuits and hence now poses risk to therapists as well as clients. (RANZCP, 2023; Exposito-Campos, 2021)

176. There is no consistent evidence that medical gender interventions improve psychological functioning better than psychotherapy, as has been previously discussed. (Elkadi et al., 2023; Dhejne et al.,2011; Bradshaw & Pachankis, 2020a; 2020b; Costa et al., 2015; Zucker, 2018; Exposito-Campos, 2021, p. 274; Cantor, 2022)

a. **Finland's government recommendation accepts a Tavistock study that found no significant difference in psychological functioning between gender dysphoric adolescents who received psychotherapy alone and those who received psychotherapy plus puberty blockers.** (Costa et al., 2015; Council for Choices, 2020; see also Cantor, 2022; Carmichael et al., 2021; McPherson & Freedman, 2023)

b. **As previously discussed, a research review commissioned by the state of Florida in the U.S. (Cantor, 2022, p. 3) and additional studies found no evidence that puberty blockers and cross-sex hormones are superior to psychotherapy for treatment of gender dysphoria in prepubescent children and adolescents.**

c. **A university medical centre gender clinic cohort study in Germany found it was relationships with families and peers, not affirmative social transitioning**

or parents support for it, that accounted for the mental health of gender dysphoric children. The clinic offered them psychoanalytic individual and family therapy. (Sievert et al., 2021) Such therapy may decrease or resolve influences predisposing to gender dysphoria. Psychotherapists help people have improved family and peer relationship skills and experiences.

177. There is a need to increase the knowledge base on psychotherapy for resolving gender dysphoria without body harms. (RANZCP, 2021; Ayad, 2021). **Clinicians, and presumably researchers as well, however, fear being accused of "conversion therapy". The MoU contributes to this fear and may have inhibited developing much needed research and clinical knowledge.**

a. **At present, case studies appear to contribute to the best available research for psychotherapy for gender dysphoria.** (Examples: Zucker et al., 2012; also Bradley & Zucker, 1990; 1997; Evans & Evans, 2021b; Kosky, 1987; Lim & Bottomley, 1983; 2001; 2004; 2005; 2006; Zucker & Bradley, 1995; 2005)

b. **Some desistance studies also appear to lend support for a psychotherapy approach.** (Singh et al., 2021; Davenport, 1986, reported several publications of successful treatments; Kosky, 1987; Wallien & Cohen-Kettenis, 2008; Evans & Evans, 2021b)

c. **The problem of paucity of research also extends to culturally sensitive treatment for the traditionally religious gender dysphoric population. Again, research and clinical expertise are needed. The guideline of the Association of Christian Psychologists in Poland proposes culturally sensitive treatment for this population based on available research.** (Polish or English: Marianowicz-Szczygieł et al., 2024)

d. **Guidelines for treating detransitioners are also needed.** (Exposito-Campos, 2021)

e. **It is to be hoped that therapists in countries that are prioritising psychotherapy for treating gender dysphoria will now be building a repertoire of clinical experience and research into such therapy.**

178. There is emerging evidence, however, for the efficacy of psychotherapy that explores the meaning, predisposing context, or pre-existing psychiatric conditions for an individual's gender distress for the purpose of increasing an individual's capacity to manage, decrease, or resolve gender distress without invasive interventions or body harms and to become contented with their natural body sex.

a. **The final Cass report indicates that well-proven therapies for conditions associated with gender dysphoria may help the gender dysphoria as well, and it says research should look at this.** (Cass, 10 April 2023, p. 150, bold and italics added)

i. **11.36 Some therapies, which are well-proven for associated mental health problems, already have a strong evidence base.** Where it is clear that children/young people have such problems, they should receive the appropriate therapies in the same way as any other young person seeking support from the NHS. **Outcome measures should include evaluating** the impact on the associated medical health condition, and **any additional impact on the gender-related concerns and distress.** (Cass, 2024, p. 150, bold added)

ii. **11.37 Beyond this first-line approach, it is important to understand how specific therapeutic modalities *may help the core gender dysphoria* and bodily distress.** (Cass, 2024, p. 150, bold and italics added)

iii. **The Cass final report says exploration of mental health problems impacting on gender-related distress is essential to appropriate intervention.** Dr. Cass says the review she conducted for NHS "maintains the position that children and young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. Exploration of these issues is essential to provide diagnosis, clinical support and appropriate intervention." (Cass, 2024, p. 150)

b. **A notable number of disorders or conditions associated with gender dysphoria have been identified. As has been reviewed, international research supports that family pathology and insecure attachment (Zucker et al, 1996, Birkenfeld, 2000, Kozlowska, Chudleigh, et al., 2021), adverse childhood experiences, bullying for reasons other than gender, psychiatric disorders, neurodevelopmental disabilities, suicidality, and self-injuring behaviour commonly exist before onset of gender dysphoria and may predispose some to believe they would feel more secure or valued as another sex.** (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Kozlowska, Chudleigh, et al., 2021; Kozlowska, McClure, et al., 2021; Council for Choices, 2020; Bradley & Zucker, 1997, eg. pp. 262-263; Zucker et al., 2012 case studies)

c. **Treatments for such conditions or trauma already exist.**

d. **It is generally accepted that treating a cause may resolve an effect.**

e. **Treatment for these many potential causes of gender distress does not require puberty blockers, cross-sex hormones, or sex surgeries.**

f. **Clients should be allowed to choose, and professionals should be allowed to provide, therapy that treats predisposing conditions and that may, as a result, naturally reduce distressing gender feelings or behaviours. It appears the MoU forbids this, especially when there is an unapproved viewpoint.**

g. **As previously stated, Finland's government recommendation for treating gender dysphoria in adolescents accepts that psychiatric disorders may predispose a young person to gender dysphoria, and accordingly its first line recommended treatment specifies treating disorders that may have predisposed to gender dysphoria.** (Council for Choices, 2020) **This recommendation is based on research in Finland that found gender dysphoric adolescents had high rates of severe psychiatric disorders that had their onset before, seldom after, onset of gender dysphoria.** (Kaltiala-Heino et al., 2015)

h. **Treatment that Finland's government recommends based on research as first line treatment should not be labeled "conversion therapy". As stated, the MoU appears to prohibit treatment Finland recommends as first line. This conflict is evidence that there is not research support or professional consensus for the MoU's prohibition which appears to be affirmative-only.**

i. **The majority of young people who were rejected in the Dutch Study, that was foundational to the gender affirming approach, from receiving medical treatment for gender dysphoria did receive psychological or psychiatric treatment for major nongender mental health problems and reported less gender dysphoria at the 4.2-year follow-up interview for the Dutch study. Few regretted not having received physical interventions. Their bodies were preserved from harm. I discussed this study previously in more detail.** (Smith, Goozen, & Cohen-Kettinis, 2001, p. 479)

j. **It is of interest that, *after about 4 years*, young people in this study who did not undergo medical interventions and who received psychological or psychiatric treatment reported less gender dysphoria** (Smith, Goozen, & Cohen-Kettinis, 2001)**, and some young people in other studies who underwent medical gender interventions and discontinued medical treatment or detransitioned did so by or around the 4 year mark, some with less gender dysphoria and some desiring therapy to achieve less dysphoria. (**Vandenbussche, 2021; Hisle-Gorman et al., 2023; Elkadi et al., 2023) More research is needed to know whether this change by the 4-year mark is partially due to the fact that some follow-up investigations extended only about 4 years (and rates of change in longer follow-up would have been greater or different) or if there is a more inherent pattern of about 4 years.

k. **Psychological support for gender dysphoric children and their families may have contributed to the high desistance rates (average 85%, range 61% to 98%) found in 11 out of 11 studies** (88% desistence rate: Singh, Bradley, & Zucker, 2021, with treatment description in Zucker et al., 2012; Steensma et al., 2010; Ristori & Steensma, 2016; Zucker 2018), **according to a research review commissioned by the Division of Florida Medicaid** (Cantor, 2022). Thorough assessment also brought to light that some children actually needed help with other underlying issues that were being presented as gender dysphoria. (de Vries & Cohen-Kettenis, 2012) Research is needed to discern

whether therapy is effective in helping children to desist or whether they desist regardless of professional intervention. (Cantor, 2022, pp. 19-20) The reviewer for Division of Florida Medicaid pointed out,

> Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound. (Cantor, 2022, pp. 6-7)

l. **The largest and methodologically strongest study of childhood gender dysphoria desistence studied boys and found 88% desisted. (Singh et al., 2021) Their successful treatment was conducted at a clinic led by Kenneth Zucker, international gender authority, that followed a therapeutic approach that a "conversion" therapy ban prohibits. The psychotherapy model and approach had the explicit goal of helping children feel comfortable with their sex, not a gender-affirming approach,** at the Gender Identity Service, Child, Youth, and Family Program at the Centre for Addiction and Mental Health in Toronto, Canada. (Zucker et al., 2012) The treatment approach at this gender service will be presented at more length below.

m. **In some additional desistence follow-up studies as well, not only were the children given psychotherapy, but the therapy had the explicit goal of helping the children come to accept and identity with their sex.** (Davenport, 1986, reported on several publications of successful treatments; Kosky, 1987; Wallien & Cohen-Kettenis, 2008) There are more studies of successful treatment that are not part of these 11 desistence studies. Some will be discussed as case studies later below.

n. **It may be that psychotherapy tends to facilitate change in childhood discordant gender identity toward or to identification with innate sex, regardless of whether there is therapist or patient intent toward change, in which case offering psychotherapy may effectively be offering change allowing therapy.** The rate at which childhood discordant gender identity successfully resolved into the child identifying with his or her sex was virtually identical for children who received psychotherapy to help it change, 88% (Singh et al., 2021; Zucker et al., 2012) and for children who received psychotherapy that treated any stressors or issues that might interfere with desistance, 85% on average (Cantor, 2022). More research is needed to know to what extent some children who receive no psychosocial support or psychotherapy also come to identify with their sex.

o. **People who were professionally diagnosed with gender dysphoria and treated with medical interventions and who then came to desist have provided emerging evidence that gender dysphoria can be resolved through insight from self-exploration.** (Vandenbussche, 2021; Littman, 2021; Steensma et al. 2010)

g. Since some detransitioners reportedly can resolve gender dysphoria or mental health problems through personal insight-oriented exploration, it seems plausible they should be able to do so with professional support.

179. There are case reports supporting that psychotherapy has successfully helped people achieve contrasting therapy goals regarding gender dysphoria either to (a) *decrease* gender related distress—that is, to decrease distress about the conflict between their gender identity and their sex—but not decrease the conflict itself (example: the cognitive-behavioural therapy approach of Canvin, Hawthorne, & Panting, 2022), or (b) *resolve* gender dysphoria by increasing comfort with one's body sex, first through exploring the context in which the person came to have negative feelings about their sexed body or feelings that their body is wrong, and then through treating the meaning or causes of the distress. *Affirmative* medical or psychological treatments--uniquely among psychiatric or psychological treatments, *affirm* people in their diagnosis. An affirmative approach does not express curiosity about the context in which gender incongruence or dysphoria developed, the possible meaning for the person, or the capacity to resolve it through psychotherapy.

180. Historically, psychoanalytic, psychodynamic, or developmental psychotherapy has been interested in the developmental context or causes of incongruent gender identity and has aimed to resolve both the incongruent gender identity and any feelings of dysphoria about it. In this therapy approach, incongruent gender identity is understood to develop from a combination of biological/temperament, psychological, social, and cognitive developmental factors.

181. Kenneth Zucker and colleagues treated gender dysphoric children with a developmental psychotherapy approach that aimed to help children become comfortable with their biological sex.

a. **Dr. Zucker is one of the world's leading authorities on gender dysphoria.**

i. **As previously stated, Kenneth Zucker, an American-Canadian research and clinical psychologist, oversaw the development of guidelines for diagnosing gender dysphoria that are used internationally. He was the Chair of the Work Group on Sexual and Gender Identity Disorders for the American Psychiatric Association's official diagnostic manual**, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (2013). This manual has been used worldwide by clinicians and researchers to diagnose gender dysphoria.

ii. **Zucker was the Psychologist-in-Chief at Toronto's Centre for Addiction and Mental Health (CAMH) Gender Identity Service from 1981 to 2015.** In 2015, activists were unhappy that Zucker was treating gender dysphoria with the predetermined goal of helping children resolve it through psychotherapy, an approach they apparently considered to be "conversion therapy". Zucker was ousted from the CAMH under allegations that CAMH later acknowledged proved to be false. CAMH apologised without reservations and paid him a settlement of over half a million dollars. ("CAMH reaches settlement", 2018) The center closed its child and youth gender identity clinic.

iii. **Dr. Zucker continues to this day to be the editor-in-chief of the eminent, peer-reviewed, professional journal, *Archives of Sexual Behavior*.** (Kearns, 2018)

b. **Zucker and colleagues: Developmental treatment according to the biopsychosocial and developmental treatment model of Zucker, Wood, Singh, and Bradley (2012). This approach is interested in and explores causes of incongruent gender identity in an individual and aims to resolve both the incongruent gender identity and feelings of dysphoria about it. The treatment goal is to "have the child feel more comfortable in their own skin", that is "to reduce the child's desire to be of the other gender". The treatment also aims to improve overall well-being and progress through developmental stages.** (p. 383, see also p. 388) Cross-gender identity is understood to develop from a combination of biological, psychological, social, and cognitive developmental factors. These may include atypical temperament (biological), parent social response to cross-sex dressing, immature childhood cognitive development of the concept of gender, co-occurring psychopathology, and transfer of conflict or trauma from parent to child that may or may not be consciously recognised by parent or child (psychodynamic factors). Cross-gender identity expression is seen as a symptom to be understood, treated, and resolved. Any co-occurring psychopathology is also treated by seeking to understand the sources of it. (The following supportive cases are from Zucker et al., 2012, except when referenced otherwise.)

i. **Biological factors:** Temperament, taken here to mean activity level and proclivity for rough and tumble play, may be influenced by genes and prenatal hormones. These biological factors are not seen as leading to an unvarying discordant gender identity throughout all stages of development, but they may lead to experiences that influence gender identity. For example, a boy who has a lower activity level by temperament might find the behaviours of girls on average more compatible with his own activity level, leading to girl playmates. This in turn may lead to greater interest in girls' toys and activities. In turn, this may have a feedback effect on his gender identity, especially during early stages of child cognitive development. (Zucker et al., 2012, pp. 375-376)

1. **Case example:** A 7-year-old boy, Frank, had a sensitive temperament. One of his brothers had a severe disruptive behaviour disorder and had often been aggressive toward him. The boy appeared to generalise his feelings with his brother to the other boys who liked rough and tumble play. He complained they were all mean to him. He played with girls, feeling they were nicer to him, and played with their toys. By age 5, he expressed that if he were a girl, all his problems would be solved. In a case like this, psychotherapy might help a boy realise not all boys are pervasively mean or aggressive. Exposure to other boys whose temperament was more like his own (perhaps in planned groups, Zucker & Bradley, 2005, p. 612) may help him develop a more refined concept of gender, that there is a variety of ways to be a boy, that there are more ways to cope with difficulties with his aggressive brother and with boisterous boys at school besides being a girl as a fantasy solution. (p. 376)

2. **Under the MoU, may a clinician explore this boy's beliefs as to what all boys are like, what all girls are like, and what are all the ways to be a boy? May such exploration be conducted only under the condition that the clinician holds the MoU approved *viewpoint*? This exploration changed how the boy perceived his gender identity. Is this outcome acceptable so long as there is no *intent* to bring the boy this relief of his gender dysphoria?**

ii. **Psychosocial factors:** Parental response to cross-dressing that is neutral or encouraging may be a perpetuating factor. (Zucker et al., 2012, pp. 376-377)

1. **Case example of psychosocial factors: parental response:** A 4.5-year-old boy, Roy, said he was a girl and had cross-dressed for 2 years prior to his parents' seeking consultation. From the start of his cross-dressing, "the parental response was to 'go with it.' They bought him stereotypical girls' toys, allowed him to wear his mother's clothes on a daily basis, and would often videotape his activities when he dressed up as a girl." The parents had never challenged his cross-dressing or identity, had never told him he was a boy. (Zucker et al., 2012, p. 277) The reasons behind their social response will be discussed a little later under a case example for psychodynamic mechanisms that may be understood and treated in psychotherapy.

2. **Social cognition**: Children may not understand until about age 5 to 7 that their sex is a fixed part of self. It would not be unusual for a 4-year-old girl to express the belief that, if she wears boys'

clothes and engages in boys' activities, she is a boy. That is, young children may conflate surface gender expressions with sex. (Kohlberg, 1966; Ruble et al., 2007) The cognitive ability to understand that a boy is still a boy even if he plays with dolls is called "object constancy." Further, young children tend to have rigid beliefs about what a boy or girl can or should do. Generally, children grow to think more flexibly about many ways to be a boy or girl. It seemed to Zucker and colleagues that some children were delayed in their cognitive development of object constancy. It was not clear to them whether such delay can precipitate gender incongruent identity, but they thought it could perpetuate it. The concept of social cognition of gender may allow us to envision how incongruent-gender-identified children may construct their subjective sense of self as a girl or boy. Zucker and colleagues give us some examples. (Zucker et al., 2012, pp. 377-378).

a. **Case examples:** A 7-year-old boy did not like to sweat, and he believed only boys sweat, so he wanted to be a girl. He also wanted to be a girl because he liked to read, and he said girls read better. An 8-year-old boy commented that parents are nicer to girls, and teachers only yell at boys, so he wanted to be a girl. (p. 378)

b. **Case example and treatment:** One 5-year-old boy talked about having a "girl's brain" because he only liked Barbie dolls. In his treatment, he created drawings of his own brain, writing in examples of what made his brain more like a girl's brain and what made his brain more like a boy's brain (e.g., when he developed an interest in Lego). Over time, the drawings of the size of his girl's brain shrank and the size of his boy's brain expanded. (p. 378)

c. From an affirmative treatment perspective, it could be argued that a child's gender identity should be taken at face value to be a permanent identity. It could also be argued, however, that caution should be taken, that we cannot assume we know what a child's gender identity will be as the child develops a more flexible understanding of a variety of ways to be a boy or a girl. (p. 378)

iii. **Co-occurring psychopathology:** This may be understood "a) as a result of social ostracism, b) as related to generic family risk factors for psychopathology; and c) as a possible cause of the GID" ["gender identity dysphoria", an older diagnostic term]. (Zucker et al., 2012, pp.

378-380) Some case examples of co-occurring psychopathology will illustrate.

1. **Separation anxiety.** In some published cases (Coates & Person, 1985), boys experienced anxiety when separated from their mother. They engaged in feminine behaviour to restore a sense of connection with their absent mother. They conflated *being* their mother with *being with* their mother. (p. 378) This has been treated through psychotherapy.

    a. **Case example of separation anxiety treatment**: For example, an 8-year-old boy began cross-dressing when his single mother had to work 2 jobs, and he felt abandoned. When he cross-dressed, he created a substitute for his mother with whom to sleep, as some children sleep with a Teddy bear at night. The process of therapy led to discovering the meaning of the cross-dressing and helped the mother think of ways to make more connection with him, for example by giving him pictures of her with which to sleep and making a couple of phone calls to him prior to bedtime. (p. 378)

2. **Autism Spectrum Disorder and gender dysphoria:** It is known that there is a higher prevalence of autism among children who experience gender incongruence or gender dysphoria than among children in the general population, as previously discussed. (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Edwards-Leeper et al., 2017; Cheung et al., 2018; Thrower et al., 2020; Kallitsounaki & Williams, 2023). Zucker and colleagues reported, “In our experience, children with GID [gender identity disorder] generally show intense, if not obsessional, interests, in cross-gender activities. This propensity for intense interests may be magnified even further in those youngsters with a co-occurring ASD [autism spectrum disorder]. Thus, a bridge between GID and ASD may be the predisposition for obsessional or focused interests and extreme rigidity in thinking.” (Zucker et al., 2012, pp. 378-379)

    a. **Case example of autism spectrum disorder and gender dysphoria:** A 5-year-old boy had both gender dysphoria and autism spectrum disorder. He would become obsessed with various ideas, each of which would last about 3 to 6 months, and which the parents would ignore. When he became obsessed with the idea that he was a girl, his parents were less certain whether they should ignore it. They bought him an assortment of girls’ things and let him wear his mother’s clothes daily. At

school, he would line up with the girls. At some point they took him to therapy where he had play therapy, and his gender identity resolved at age 7. He moved from his obsession with being a girl to other obsessions, such as an obsession that he was a computer or an obsession with a heavy metal music band. He continued therapy for other difficulties he also had. At age 9, "He reflected on the reinforcing aspects of many of the feminine interests and behaviors he had had (e.g., the feeling of pretend long hair, how 'beautiful' things looked, etc.), with a focus on the associated visual and tactile stimulation." (Zucker et al., 2012, pp. 379-380).

3. **Post-traumatic stress disorder and gender dysphoria:** A child may feel that if they had been the opposite sex, a traumatic experience would not have occurred, and they never want that traumatic experience to occur again. Psychotherapy has helped such victims by discovering the trauma as the source of the cross-sex identity, treating the trauma, and helping the child feel happy as the biological girl or boy they are.

    a. **Case example of post-traumatic stress disorder and gender dysphoria:** A 9-year-old girl, Rose, wanted to be a boy because, when she was 4, she experienced finding her dead mother at the foot of the stairs after a boyfriend murdered her mother. The girl's solution to her post-traumatic stress disorder was a fantasised boy gender self. She reasoned, "Boys are stronger than girls. Had I been a boy, I could have prevented my mother from being murdered." (Zucker et al., 2012, p. 381.) The authors presented this case as an example of psychodynamic mechanisms, but it is also an example of co-occurring psychopathology, for which I have chosen to use it here.)

    b. Case example of post-traumatic stress disorder and gender dysphoria: A young girl was raped by 2 older boys, but they did not attack her brother who was present. She felt that, had she been a boy, this would not have happened to her. Thereafter, she believed she was a boy and began to behave aggressively toward girls at school to act as a boy. Treatment: The school psychologist explored with her the context in which her identity as a boy arose, treated her for the trauma, and helped her feel good about being a girl. **She grew up to marry a man and have children, an outcome about which she as an adult expresses happiness and that**

would not have happened if she had been affirmed as a boy, been sterilised, and not been treated through psychotherapy. It appears that her therapist worked from an MoU unapproved viewpoint that something happened to lead to the girl's discordant gender identity, that feeling contentment with her sex would be preferable, and that the therapy goal was to help her identify with her sex. (This case comes from a published autobiographical account, Brewer, 2021)

iv. **"Psychodynamic mechanisms** can be understood, in part, as a transfer of unresolved conflict and trauma-related experiences from parent to child" that may or may not be consciously recognised by the parents (but still played out) or by the child. (Zucker et al., 2012, p. 380)

1. **Case example of psychodynamic mechanisms—why parents did not challenge cross-sex behaviour and identity—case of Roy discussed above:** Both parents had been traumatically shamed as children, and they worried that if they told Roy he was not a girl, he might feel the same traumatic shame as they had felt. The mother had been emotionally and physically abused by her father, and she may have worried that, if Roy engaged in typical masculine behaviour, he might be an abuser in the making. (Zucker et al., 2012, pp. 381-382, 377)

2. **Case example: pathological gender mourning by a mother:** A 4-year-old boy, Jim, had a strong desire to be a girl. He was born as the fourth of 4 boys. His mother had strongly desired a daughter and saw her fourth child as her last chance for one. After the birth of the boy, she wanted little to do with him for weeks. This was a rare reaction upon giving birth that is known as "pathological gender mourning." The therapists considered trying to help the mother become able to understand what having a daughter meant for her and help her grieve her loss. They also wondered "how the mother's disappointment/despondency might have been transmitted to him across his development." (Zucker et al., 2012, p. 382)

v. **The parents' views of masculinity and femininity** may affect the child's valuing of femininity or masculinity. For example, are men viewed as either ineffectual or dangerous, whereas women are viewed as responsible and powerful? (Zucker, 1985, p. 142) Or are men viewed as aggressive and dangerous, whereas women are viewed as unable to defend themselves? (Bradley & Zucker, 1990, p. 482)

1. **Case example of a boy** (Lim & Bottomley, 1983) Robert began cross-dressing at 2 years old. By 5 ½, his mother was

uneasy that he preferred girls' clothing, his grandmother's jewelry, dolls, play at domestic activities, and collecting and drawing pictures of women. The family background was that Robert's mother, grandmother, and father all had witnessed parent conflict and felt protective of their mother and hostile toward their father. Robert's father had been aggressive as a young man and now preferred to be passive and did not want his son to make the same mistakes he had made. Robert's mother had wanted a girl and felt caring for Robert as a baby was joyless. As Robert grew a little older, there was concern that it would be dangerous for Robert to play with the neighborhood boys in rough and tumble play, so he played alone or with girls. A masculine role was not valued. The mother was hostile toward her husband when he drank and when he was sober. She was afraid to feel dependent on her husband, felt lonely, and took comfort in Robert sleeping in their bed. She was helped to understand that turning to him placed a burden on him. The grandmother dominated Robert's mother who dominated Robert's father. The retired grandmother was lonely and enjoyed Robert spending time with her doing housekeeping activities together. A social worker met at different times with the parents and grandmother. The grandmother came to understand she felt guilt that she had had to leave her own children to work. She stopped competing with her daughter to be the better mother for Robert, got a life of her own, hid her jewelry so Robert could not play with it, and encouraged Robert to play with his uncle and other boys. She even became less hostile toward his father. The parents' relationship improved as Robert's mother came to accept her husband for the real person he was, not violent or aggressive but kind and weak. A male therapist saw Robert in play therapy and helped him recognise what behaviour was effeminate. Attempts to simply reward masculine behaviour did not work. Robert improved when the therapist helped him understand his fear of repercussions if he played cowboys and Indians aggressively. The therapist also helped Robert understand that as he turned more to sharing masculine activities with his father and other boys, he was worried about whether his mother would be all right. With Robert's own therapy and the changes his family members made, Robert's effeminate behaviour progressively fell away, and he enjoyed masculine relationships and behaviours. (Lim & Bottomley, 1983; Zucker 1985 cited this case.)

2. **Case example of a girl** (Bradley & Zucker, 1990): The girl has a biological tendency or temperament for activity and motion and for poor anxiety tolerance. The mother is seen as depressed or inadequate, while the father tends to be aggressive or to have a negative or devalued view of women. There may be overt conflict between the parents which the girl sees as threatening to her mother who she sees as unable to defend herself. The girl feels overwhelming anxiety in the situation and feels somewhat less anxious if she is aggressive like her father. When she sees herself as aggressive, she may fantasise herself protecting herself and her mother. If her need to be aggressive like a man is not discouraged by her parents, she may begin to solidify a fantasised male self. Because people may accept masculinity in a girl more than they accept femininity in a boy, she may not experience the same negative effect on her self-esteem that gender discordant boys do. (Bradley & Zucker, 1990, p. 482)

vi. **Under the MoU, clinicians are afraid to explore the possibility that discordant gender identity means something has happened to the child that needs attention, explore underlying meaning, and treat causes with psychotherapy. In the approach of Zucker and colleagues (2012), parents are helped to think of the surface gender behaviours as symptoms to be understood** (p. 388), and children are helped to "work through the gender dysphoric feelings." (p. 390) Typically, improving peer relationships is addressed, because it is often in peer relationships that gender identity gets consolidated. (p. 389) Of course, a goal is to improve the child's overall well-being and success in moving through developmental steps. (p. 393)

182. Dr. Kenneth Zucker, a research, academic, and clinical psychologist and recognized world authority on gender dysphoria, advocated for and taught psychotherapy, that the MoU forbids, in publications of the American Psychiatric Association and at leading universities.

a. **Dr. Zucker is a recognized world authority on gender dysphoria. He oversaw the development of the guidelines for diagnosing gender dysphoria that are used by mental health specialists and researchers internationally. That is, he was the Chair of the Work Group on Sexual and Gender Identity Disorders for the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders**, Fifth Edition***, and was on the Task Force for that edition of the manual overall. (American Psychiatric Association, 2013, pp. vii, x, 451-459) He also was a member of the Subcommittee on Gender Identity Disorder for previous editions (DSM-III-R and DSM-IV). (Reported in Zucker, 2006; 2020)

b. **Research distinctions for Zucker are that he was President of the prestigious International Academy of Sex Research, whose members must be scholars in sex research and must be elected to membership, and he has been the Editor of the organization's eminent scientific journal, *Archives of Sexual Behavior,* since 2002. (Zucker, 2006; 2020) Dr. Zucker has himself published more than 300 peer reviewed articles and book chapters on gender dysphoria.**

c. **Clinical distinctions, as previously stated in this report, are that Zucker oversaw clinical services treating gender dysphoria for many years.** He was Psychologist-in-Chief at the Centre for Addiction and Mental Health in Toronto, Canada (2001-2015). He also held leadership positions at the Clark Institute of Psychiatry (1991-2000). (Zucker, 2020)

d. **Advocacy distinctions include that Dr. Zucker advocated for a gender dysphoric client's right to have a therapy goal to resolve gender discordance.**

   i. Zucker and colleagues wrote, (Zucker, Lawrence, & Kreukels, 2016, p. 237)

> **If a client with GD [gender dysphoria] decided that overt cross-gender expression carried too great a risk of unacceptable consequences and requested a psychotherapist's help in trying to make their gender identity and gender expression more congruent with their assigned sex**, would the therapist's participation always be unethical, as the SOC-7 [World Professional Association for Transgender Health, Standard of Care, version 7] seems to assert? If so, the SOC's position would seem to conflict with the client's right to autonomy and self-determination. Perhaps the overarching treatment goal of psychotherapy for GD—"long-term comfort in . . . gender identity expression, with realistic chances for success in . . . relationships, education, and work" (Coleman 2011, p. 184)—could sometimes best be achieved by supporting clients in a decision to forego gender transition or overt public cross-gender expression. This psychotherapeutic aim, which was explicitly set forth in version 6 of the SOC [i.e., "acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression" (Meyer et al. 2001, pp. 19–20)], was expunged from the SOC-7.

   ii. **A young person may aspire to be in such adult roles comfortably, for example may aspire to enter an opposite sex marriage as a person fully identified with and comfortable with their sex.**

e. **Research evidence supports the effectiveness of clinical care Dr. Zucker taught and for which he advocated** that has the intent to help a person become comfortable with their sex and change their perception of themselves to identify with their sex and not want to be another sex.

i. **Zucker collected clinical and research data on gender disturbed children from 1978 to 2020. As previously stated, his publication list is long. (Zucker, 2020)**

ii. **Case studies. In an area of still emerging research, case studies may be the best available evidence. Zucker and others have published a reasonable number of case studies** of successful treatment for helping the client to feel comfortable with their sex and identify with it. (Examples: Bradley & Zucker, 1990; Lim & Bottomley, 1983; Zucker, 1985; 2001; 2004; 2006; Zucker & Bradley, 1995; 2005; Zucker et al., 2012) There are published cases of children who were gender discordant as early as age 2 who were helped to accept and identify with their sex. (Kosky, 2987) The Gender Exploratory Therapy Association's Clinical Guide for Therapists Working with Gender-Questioning Youth, Version 1 (2022) has case studies that include examples of children coming to identify with their sex as a therapy outcome, although that is not a goal of GETA's exploratory therapy. (Ayad et al., 2022)

iii. **Desistance research. The largest and methodologically best study of desistance of childhood gender dysphoria is a follow up study of children who were referred to and assessed by the Toronto gender clinic** where Zucker and colleagues treated children, and the children were subsequently followed up as adolescents or adults. This study has been referred to elsewhere in the present report. (Singh et al., 2021)

1. The researchers described their study as follows:

> The participants were 139 boys ("birth-assigned males") who, in childhood, had been referred to and then assessed in the Gender Identity Service, Child, Youth, and Family Program at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario between 1975 and 2009 (Mean year of assessment, 1989.36) and were adolescents or adults at follow-up (Mean year at follow-up, 2002.35). (Singh et al., 2021, p. 4)

2. The outcome was that, for 88% (87.8%) of the boys, gender dysphoria or incongruence resolved, and they came to identify with their sex. As the researchers reported,

> At follow-up, gender identity/dysphoria was assessed via multiple methods…. Of the 139 participants,… (87.8%) were classified as desisters. (Singh et al., 2021, abstract)

3. The researchers tell us this about treatment the boys received:

> In our own sample, the kinds of treatments that the boys received, if any, were quite variable but it is beyond the scope of this article to describe them in general [however, for examples, see (136, 140, 141)]. It can, however, be said with certainty that the vast majority of boys were seen during a particular period of time when the therapeutic approach of recommending or supporting a gender social transition prior to puberty was not made. (Singh et al., 2021, p. 14)

4. The three references given to describe the treatment "that the boys received, if any" begins with an article from which I have previously presented at length (Zucker et al., 2012) that says the "therapeutic approach" was organized around the "goal" to have the child "feel more comfortable in their own skin", that is, to reduce the child's "desire to be of the other gender" (p. 4). The other two references are to chapters on his gender dysphoria treatment that has this same goal, authored by Zucker in books published by the American Psychiatric Association. (Zucker, 2004; 2006)

f. **Educator distinctions for Dr. Zucker include that he has taught psychotherapy to resolve gender dysphoria at renowned universities and in publications of the American Psychiatric Association.**

i. **At leading universities, he taught courses on psychopathology of childhood and *specifically taught courses titled "Psychosexual Differentiation and Its Disorders" and "Seminar on Gender Dysphoria, Behavioral Disorders in Children".*** He gave instruction at the University of Toronto over the period of 1978-2017 and held faculty positions at the University of Toronto (1986-2020) and York University (Toronto, Canada, 1985-2016). These universities have been recognized as being among the world's highest ranked. Toronto University has been ranked number one in Best Global Universities in Canada and number 17 in Best Global Universities. (U.S. News and World Report, retrieved 3 October 2024). York University in Toronto, Canada has been ranked number 35 in Best Global Universities out of more than 2,250 universities. (Times Higher Education World University rankings, 2024)

ii. **Of particular note, one of the books in which Zucker taught and advocated for therapy to help a client feel comfortable in their body and identify with their sex is the American Psychiatric Association's *DSM-IV-TR Casebook, Volume 2. Experts Tell How They Treated Their Own Patients.***

1. **It is obvious from the title and from Zucker's inclusion in this volume that the American Psychiatric Association recognized Zucker as an expert, specifically in the area treating gender dysphoria, and valued his teaching his treatment approach to psychiatrists and to other mental health professionals generally.** In the experts' casebook, Zucker showcased successfully helping a child become comfortable, confident, and happy with his sex and identify with it.

2. **The American Psychiatric Association's *Casebook* quotes Dr. Zucker *boldly* discussing his treatment recommendations** in the case he presented, saying, (Zucker, 2006, pp. 321-334, bold added)

> **In my view, my recommendations were consistent with a variety of approaches that have been identified in the treatment literature** (Coates and Wolfe 1995; Zucker 2001; Zucker and Bradley 1995). **It differed, however, rather substantially from one competing paradigm, which takes the position that "gender variance" is not a mental disorder, that children such as Brian should be accepted as they are and that therapists, such as myself, 'who advocate changing gender-variant behaviors should be avoided'** (Menvielle et al. 2005).

iii. **Also of note, Zucker was called upon to educate psychiatrists in *The American Psychiatric Publishing Textbook of Child and Adolescent Psychiatry*, 3rd edition.** He and Bradley wrote a chapter on gender identity and psychosexual disorders that included teaching their approach to helping a minor become comfortable with their sex and identify with it. (Zucker & Bradley, 2005)

iv. Zucker's work on treating gender dysphoria appears in additional publications of the American Psychiatric Association. (Zucker, 2020)

v. It may be argued that in recent years, some professional organisations have been captured by gender ideology that is not supported by the best-available research or by professional consensus.

183. Should the therapy goal of decreasing gender distress by helping individuals become more comfortable identifying with their natural sexed body and enjoying what it has to offer be banned as "conversion therapy"?

a. The Cass Report said, (Cass, April 2024)

> **11.5** Whilst the Review's terms of reference do not include consideration of the proposed legislation to ban conversion practices, it believes that no LGBTQ+ group should be subjected to conversion practice. It also maintains the position that children and young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. **Exploration of these issues is essential to provide diagnosis, clinical support and appropriate intervention.**
>
> **11.6** The **intent** of psychological intervention **is not to change the person's perception of who they are** but to work with them to explore their concerns and experiences and help alleviate their distress, regardless of whether they pursue a medical pathway or not. **It is harmful to equate this approach to conversion therapy** as it may prevent young people from getting the emotional support they deserve.
>
> **"11.7 No formal science-based training in psychotherapy, psychology or psychiatry teaches or advocates conversion therapy**. If an individual were to carry out such practices they would be acting outside of professional guidance, and this would be a matter for the relevant regulator." (Cass, April 2024, pp. 150-151)

b. **The passage may be taken to imply exploratory therapy is not "conversion" therapy, because the "intent" is not to change the person's perception of who they are.** Therapy bans such as the MoU and proposed legislative bans commonly prohibit a therapist's intent to help a person change their perception of their gender. **However, Dr. Zucker and his colleagues have successfully conducted psychotherapy that had the *intent* to help children change their *perception of who they are*, and it would be absurd to prohibit their successful therapy that brought relief.**

c. **What does this statement mean? "No formal science-based training in psychotherapy, psychology or psychiatry teaches or advocates conversion therapy." (Cass, April 2024, 11.7) Whatever this passage means by "conversion therapy," it is not true of therapy that has an "intent" to "change the person's perception of who they are". Zucker, a recognised world authority on gender dysphoria, *both taught and advocated* for therapy that has an intent to change how a person perceives their gender identity, and case studies and follow-up research of boys referred to his clinic support that it was effective.**

d. **The Cass Report also said, "an individualized care plan" should be "based both on evidence, and the person's individual preferences, beliefs and values" (Cass, April 2024, 10.74-10.75).** The Cass report says,

> **"10.74** The holistic needs assessment and subsequent formulation should lead to the development of **an individualised care plan** with input from the multidisciplinary team." (Cass, April 2024, p. 145, bold added)
> **"10.75 This should be a collaborative process that involves a young person and their healthcare professional working together** to reach a joint decision about care. Shared decision making involves choosing treatments **based** both on evidence, and **on the person's individual preferences, beliefs and values** (NICE, 2021)".
> (Cass, April 2024, p. 146, bold added)

e. **For some individuals, such as those who want to live consistently with their religion or, in the case of some adults, who want to preserve their marriage and family, therapy to reduce their gender distress may mean therapy to help them forego medical transition or cross-dressing and to explore their potential to become able to feel comfortable with and identify with their sex. For some people, this is therapy based on their preferences, beliefs, and values. The purpose of the therapy is to reduce their gender distress, and the means, which may also be the intent, is to change how they perceive themselves and more closely align their gender perception with their innate sexed body.**

184. **For these individuals, change-allowing therapy for gender dysphoria may be thought of as exploratory psychotherapy *plus* the therapist's openness to a client's preference and desire to become comfortable with their sexed body.** The Clinical Guide for Therapists published by the Gender Exploratory Therapy Association (Ayad et al., 2022) takes the position that exploratory therapy does not have a predetermined therapy outcome goal to resolve gender dysphoria or incongruence. If a male came to an exploratory therapist and said, "My grandmother dressed me in a purple dress. I felt loved as a girl and never as a boy. My uncle sexually abused me. Will you help me explore these experiences and my potential to become happy being a boy/man?" should an exploratory therapist say, "No"? (Heyer, 2024) **The point of the *therapist* not having a predetermined therapy outcome goal is to respect *the client's self-determination.***

185. **For clients whose desire is to resolve gender dysphoria by resolving gender incongruence, a change-allowing therapist may conduct an evaluation and exploratory therapy *in collaboration with* the client's therapy goal. To the degree that the person's gender identity becomes more aligned with the person's sex, the outcome occurs as a by-product of exploratory therapy and treatment of trauma or other difficulties rather than by simply guiding the client directly toward the stated goal.**

186. **Drs. Zucker and Bradley graciously helped make a video that trains Christian therapists who not only want to conduct therapy with this MoU unapproved goal but also want to integrate the therapy with their traditional Christian, not MoU approved, viewpoint.** If Drs. Zucker and Bradley were to provide this kind of help in the U.K., should an MoU signatory or Parliament punish them? Is helping people be happy with their sex and practice their religion forbidden in the United Kingdom?

187. **Some psychotherapists are already treating the distress of some gender discordant individuals by exploring the context in which gender discordance emerged. Such psychotherapists include exploratory psychotherapists** (recommended for NHS-England, 2022; UK Council for Psychotherapy, 2023; Ayad et al., 2022, "A Clinical Guide for Therapists Working with Gender-Questioning Youth, Version 1"—the GETA clinical guide), **developmental psychologists and psychoanalysts** (Zucker et al., 2012; Evans 2020; 2023; Evans & Evans, 2021a; 2021b), **and change-allowing therapists** who are open to a detransitioner's or gender discordant person's desire to explore their gender distress and their potential to become comfortable with their natal sex (IFTCC, 2023b; ACPP, 2023, "Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues"—standards and guideline appropriate for patients of traditional Christian religion)**. Such therapies should not be dismissed as "conversion therapy", and the MoU does not have incontrovertible scientific research justification for prohibiting them or for enforcing that only interventions that are within the boundaries of a therapist's or organisation's predetermined affirmative viewpoint may be accepted.**

188. **The MoU forbids psychotherapy that has been conducted, formally taught to train psychiatrists and other mental health professionals, advocated, and supported by the best available evidence—case studies and relevant research—by a leading world authority, Kenneth Zucker, and colleagues that has the intent to decrease gender distress by changing how a person perceives who they are based on preferences, beliefs, and values—notably based on viewpoints—that favour helping an individual feel more comfortable with and identify with their own innate sex. Therapy that intentionally explores the potential for this outcome should be considered legitimate clinical work. The MoU prohibition of such therapy does not have professional consensus in support of it.**

MEETING CHALLENGES TO CHANGE-ALLOWING THERAPY

XIII. CHALLENGES TO CHANGE-ALLOWING THERAPY

189. **Thus far I have reviewed the MoU's affirmation-only viewpoint with its consequent discrimination and harmful unintended consequences, failure to provide incontrovertible scientific justification, invalid treatment of sexuality and gender identity as though they are innate traits that cannot be changed through life events, and support for harmful gender-affirmative-only interventions for all ages but prohibition of consensual therapy conversations. I have also introduced positive evidence for the safety and effectiveness of change-allowing therapy that overall**

decreases distress, improves well-being, and may or may not result in sexuality or gender identity changes. With this background, the next sections now address challenges to change-allowing therapy.

190. The often-misrepresented "Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation" ("APA Report" 2009), which addressed only sexuality and not gender dysphoria, actually found no research that met scientific standards that showed contemporary change-allowing therapy is potentially harmful, ineffective, or leads to suicide for adults or minors. By its own admission, the APA Report's recommendation against "sexual orientation change efforts" ("SOCE") was not based on research that met its own scientific standards. (p. 42. Standards: p. 90) Yet, internationally, opponents of change-allowing therapy often cite the APA Report as concluding from research that such therapy is *always or at least usually* harmful and ineffective. The earliest MoU (2015) relied on this review.

a. **The APA Report drew a distinction between early aversive behaviour therapy and contemporary therapy and said, "[W]e cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (p. 43), and "Thus, we cannot conclude how likely it is that harm will occur from SOCE [sexual orientation change efforts]."** (p. 42)Yet the APA Report discouraged contemporary therapy anyway, admittedly without justifying scientific evidence.

i. **The APA Report said, "These studies were all conducted in the period from 1969 to 1978** and used aversive or other behavioral methods. Recent SOCE differ from those interventions explored in the early research studies." (p. 82)

ii. **Aversive methods were used in the 1970's when behaviourism was a leading, mainstream form of general psychotherapy in the U.S.** Behaviourists applied principles of rewards and punishments toward a variety of behavioural goals. These methods were not developed just for treating undesired same-sex sexuality.

iii. **That the aversive methods were abandoned decades ago and are historical is accepted** not only in the APA Report (2009, p. 82), but also from other opponents of change exploring therapy. They include indirect support from an article which the first MoU (2015) referenced (Bartlett et al., 2009), the review by Serovich et al. (2008), an early guideline of the British Psychological Society (Shaw et al., 2012, pp. 71-72), and the RCPsych (2014) paper, "Response to the Pilling Commission (2012) and the Church of England Listening Exercise on Human Sexuality (2007): Psychiatry and LGB People".

iv. **Some opponents of therapy that is open to a client's goal of change speak as though these methods are characteristic of professional psychotherapy in North America and the United Kingdom today,**

whether claimed in ignorance or deceptively or for effect, but to the best of our knowledge this is a misrepresentation. Professional organisations in the U.K. (International Foundation for Therapeutic and Counselling Choice) and the U.S. (Alliance for Therapeutic and Counselling Choice) for therapists who are open to change-allowing therapy strongly oppose such methods and have strongly opposed them throughout their entire histories.

b. **The task force applied its standards unevenly. No research on which the APA task force relied, indeed no research to date that claims harm from SOCE, has met the standards the APA task force required of research on SOCE.** (APA Report, 2009, p. 34, Standards p. 90; Sullins 2022b; 2023a; 2023b; Rosik, 2022)

c. **Putting the findings of the APA Report on SOCE into perspective, a systematic research review published 2 years before the APA 2009 Report (King et al., 2007, p. 2) found no research on *any* service or therapy for LGBT-identified people that met scientific standards., including affirmative therapy.** "There were no trials evaluating the effectiveness of psychological interventions in LGBT people, nor were there any longitudinal follow-up studies of people who had received a specific service or therapy."

d. **The APA task force failed to mention that all the research it relied on for its own claim that stated, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA Report, 2009, p. 23) also did not meet its standards. (Rosik, 2012)** The APA Report said it based its "Recommendations" on "scientific facts" that included that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma." (APA Report, 2012, p. 86) There is, however, research to the contrary, as the *APA Handbook on Sexuality and Psychology* acknowledged 5 years later (2014, vol. 1, pp. 609-610 re Wilson & Widom, 2010, discussed here below).

    i. There are several population-based studies that have found that higher rates of adverse childhood experiences, family dysfunction and instability, and opportunity are *associatively* linked to development of same-sex sexuality. (Blosnich & Andersen, 2015, Brown et al., 2015, Corliss et al., 2002; Trans, Henkhaus, & Gonzales, 2022; Wells, McGee, & Beautrais, 2011; Laumann et al., pp. 309-310). These alone do not prove causation but raise the possibility.

    ii. There are also several large, prospective, longitudinal, controlled, cohort-based studies that have found *associative and potentially causal* links to same-sex sexuality. Potentially causal influences included psychological distress (depression, anxiety), risky sexual behaviour, childhood sexual abuse, family risky relationships, and family instability including absence or loss of a parent, especially the

parent of the same sex as the child. These findings have come from the U.K., Finland, the U.S., and New Zealand. (Finland: Oginni et al., 2022 and its replication study, U.K.: Oginni et al., 2023; U.S.: Wilson & Widom, 2010 and comment in Mustansky, Kuper, & Greene, 2014, *APA Handbook of Sexuality and Psychology, vol. 1*, pp. 609-610; Francis, 2008; Udry & Chantala, 2005; Bearman & Bruckner, 2002; Fish & Russell, 2018 on the "Ad Health" data set on adolescents used for Francis, 2008 and Udry & Chantala, 2005 and Bearman & Bruckner, 2002; New Zealand: Fergusson et al., 1999 and Zietsch et al., 2012)

iii. Five years after the APA Report (2009), the *APA Handbook of Sexuality and Psychology* (2014) accepted that childhood sexual abuse has "associative and potentially causal links" to subsequently having same-sex partners based on research that included one of these studies whose methods it praised. (Mustanski, Kuper, & Greene, 2014, in *APA Handbook*, *vol. 1*, pp. 609-610 re Wilson & Widom, 2010)

iv. A question has been raised, "Does child abuse lead to same-sex attraction, or does same-sex attraction lead to a child being abused?" Those who have raised this question have equated gender nonconforming expression with early same-sex sexuality. A large, population-based study of adolescents assessed nonconforming gender behaviour separately from LGBTQ identity in order to address this question. It found most LGBTQ-identified adolescents did not appear to manifest gender nonconforming behaviour, and those who were more gender nonconforming reported more childhood abuse to a small though statistically significant degree. (Baams, 2018) Gender-nonconforming expression may influence some unstable parents to abuse their children in some ways. It seems unlikely, however, that childhood gender-nonconformity would cause all higher rates of adverse childhood experiences of children who come to experience same-sex attraction, behaviour, or identity. Adverse childhood experiences that have been found in research to be higher for children who developed same-sex sexuality include household mental illness, household substance abuse, incarcerated household member, parent separation or divorce, exposure to domestic violence, physical abuse, emotional abuse, and sexual abuse. (Blosnich & Andersen, 2015, Table 2) Not all experienced these. But it is possible for those who did that witnessing these behaviours in parents and suffering greater child abuse led some children or adolescents to feel they would be more safe or valued presenting more like or actually identifying as another sex. Some of our clients report they did not want to be like a parent they saw as weak or abusive, or they did not feel safe as a member of their own sex. Some feel that, for them, trauma or adverse family experiences were an influence on their gender expression, sexuality, or gender identity. The APA task force chose not to include

practitioners who could have represented these indivduals in the task force report.

e. **A "key" scientific finding on which the APA authors said they "built" their conclusion and recommendations, that sexual orientation, by which the authors meant attraction** (pp. 54-55)**, does not appear to change through life events** (pp. 63, 86, see also 2, 54, 77)**, was invalid,** as the *APA Handbook of Sexuality and Psychology* (2014) subsequently documented based on research. (Diamond, vol. 1, chapter 20, p. 636; Rosario & Schrimshaw, vol. 1, chapter 18, p. 562; Mustanski, Kuper, & Greene, vol. 1, chapter 24, p. 619) (See discussion of research on change at "V. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan".)

f. **The task force said it had no research that met its standards for discerning the safety or effectiveness of either affirmative therapy or change-allowing therapy.** Yet, as further evidence of its bias, only in the case of change-allowing therapy did it make recommendations as though lack of evidence equalled evidence of lack, an invalid scientific inference. Further, it gave a pass to research reporting harm that did not meet its standards to which it held SOCE and based its recommendations on it. (APA Report, pp. 86-122)

g. Research that has been published over a century, from the late 19th century forward, has reported that people changed sexual attraction and/or behaviour to varying degrees as an outcome of professional assistance. (Phelan, Whitehead, & Sutton, 2009, see references, pp. 95-121).

h. Given the APA Report's invalid premise that sexual orientation does not appear to change through life events and its invalid tendency to interpret partial success as no change, it morphed research reports that some people said they successfully experienced changes in sexual attraction into saying that those who reported change through therapy just experienced "positive benefits" from "support" (APA, 2009, p. 85). It should have, as a bare minimum, given at least as much weight to the more than 100 years of publications reporting change and used them as anecdotal evidence of safe change, as it used publications reporting harm as anecdotal evidence. If it had done so, I believe its conclusion and recommendations would have looked far different.

i. I can personally testify that the selection of members for the APA Report task force was biased. When the chair of the task force was forming its membership, I wrote to her urging that APA members who were clinical and research experts in providing change-allowing therapy be allowed to serve on the task force, and I personally received a letter from her refusing. I do thank her for replying. But the result of her decision was that only individuals who were already philosophically or politically committed to the report's predetermined conclusions were invited. I believe that if the task force had been truly interested in pursuing truth, it would have included members representative of varying views.

j. **There is no research that demonstrates that LGBT-identity-affirmative therapy is safe, effective, or affirmative for the subpopulation of same-sex attracted individuals who regard religious identity, and not LGBT identity, as their identity**.

k. **The APA Report in 2009 cited no research (because it appears that none existed) showing LGB-identity affirmative therapy is better for improving mental health for the client who does not want or consent to affirmative therapy and who desires therapy that is open to support for and exploration of their potential to manage, reduce or change same-sex attraction or behaviour. To this date, no such research appears to exist. It would be unethical even to conduct research on such nonconsensual therapy.**

191. A high court in the US in Oct. 2020 found the scientific case of the American Psychological Association against change-allowing therapy to be weak. The APA submitted arguments to the U.S. 11th Circuit Court of Appeals in support of a city therapy ban in Boca Raton, Florida. **The Court overturned the therapy ban, and in its decision, summarised and critiqued the American Psychological Association's arguments as follows,**

> Defendants say that the ordinances "safeguard the physical and psychological well-being of minors." Together with their amici, they present a series of reports and studies setting out harms. But when examined closely, these documents offer assertions rather than evidence, at least regarding the effects of purely speech-based SOCE. Indeed, a report from the American Psychological Association, relied on by the defendants, concedes that "nonaversive and recent approaches to SOCE have not been rigorously evaluated." In fact, it found a "complete lack" of "rigorous recent prospective research" on SOCE. As for speech-based SOCE, the report notes that recent research indicates that those who have participated have mixed views: "there are individuals who perceive they have been harmed and others who perceive they have been benefited from nonaversive SOCE." What's more, because of this "complete lack" of rigorous recent research, the report concludes that it has "no clear indication of the prevalence of harmful outcomes among people who have undergone "SOCE." (Otto et al. v. City of Boca Raton, Florida et al., Nov. 20, 2020, p. 20)
>
> The Court further said, "The dissent's claim that a 'mountain of rigorous evidence' supports the ordinances is in serious tension with this acknowledgment of the *lack* of rigorous research on nonaversive SOCE." (p. 20, footnote 7)
>
> Further, the Court had this to say. "We focus our attention on the APA's 2009 task force report because it "performed a systematic review of the peer-reviewed literature" to assess SOCE [sexual orientation change efforts]. Many of the other reports cited by the dissent—including those from the World

Health Organization and the U.S. Department of Health and Human Services—primarily rely on the APA's task force report to draw their own conclusions about SOCE. So we choose instead to discuss the APA's report directly. Additionally, we discuss the APA's 2009 report, rather than its 1998 resolution, because the 2009 task force was specifically asked to "[r]eview and update" the 1998 resolution. Finally, we note that very little of the APA report considers evidence solely related to purely speech-based therapy." (p. 20, footnote 8)

192. The American Psychological Association itself, while it has opposed sexual orientation change efforts, has never declared sexual orientation change efforts unethical. I have been a member of the American Psychological Association for more than 40 years. Neither I nor my colleagues who have offered change-allowing professional care have ever been charged by the American Psychological Association with being unethical or had our licences revoked by our state government. The APA has published our letters to the editor of the *Monitor on Psychology* (which is sent 10 times a year to all APA members) regarding our views that disagree with the APA position. (Example: Rosik & Kim, 2017) We have written research comments more than once in support of change-allowing therapy and sent them to APA members of the Society for the Psychology of Sexual Orientation and Gender Diversity and members of the Committee on Sexual Orientation and Gender Diversity whose members write the position statements of the APA on sexual orientation or gender identity change efforts. We were personally thanked for the thoroughness of our comments. (Haynes & Rosik, 2023)

193. Several American Psychological Association presidents have supported change-allowing professional care and differed with those who oppose it in the APA.

a. For example, former APA President Nicholas Cummings (1979), who sponsored the 1975 APA resolution stating homosexuality is not a mental disorder and the 1976 resolution that gays and lesbians should not be discriminated against in the workplace, and who supported same-sex marriage, also energetically supported their right to choose change-allowing therapy. As chief psychologist for Kaiser-Permanente, a large private health care organisation, from 1959 to 1979, when the homosexual population burgeoned in San Francisco where Cummings was based, he reported he saw hundreds change their sexual orientation through therapy and live very happy heterosexual lives. (Cummings, 2013) Dr. Cummings also wrote an endorsement for a book on Reparative Therapy® by Dr. Joseph Nicolosi, Sr. entitled *Shame and Attachment loss; The Practical Work of Reparative Therapy* (2009).

b. More APA presidents have affirmed a client's right to change-allowing therapy. Former APA president Dr. Robert Perloff (1985) gave the keynote address at the 2004 annual conference of the national professional organisation for change-allowing therapists in the U.S. He said, "every individual has the right to claim a gay identity, or to develop their heterosexual potential." He

accepted an award from the organisation in 2008.[10] More APA presidents who supported a client's right to change-allowing therapy have included Frank Farley, 1993, Martin Seligman, 1998, Gerald Koocher, 2006, Alan Kazdin, 2008, and James Bray, 2009. (Nicolosi, 2014)

c. **Note well: the APA task force (2009), the British Psychological Society (Shaw et al., 2012), and the British Association for Counselling & Psychotherapy (King et al., 2007) accepted affirmative therapy that they acknowledged lacked any research that met scientific standards to show safety or effectiveness. Any claim they might make that they oppose change-allowing therapy for supposedly lacking such evidence would appear to be disingenuous.** There are researchers who have in recent times continued to report gaps in evidence for the effectiveness of LGBT-identity affirmative therapy.

d. The early guideline of the British Psychological Society (Shaw et al., 2012) said of LGB-identity-affirmative therapy, "There is limited empirical support for affirmative practice…" (p. 71), and of gender-affirmative body changing treatments it said, "It is important to note that the treatment of Gender Identity Disorder (APA, 2000a) in young people is largely experimental" (p. 35), and yet it did not call for the censorship of either.

e. The British Association for Counselling & Psychotherapy (BACP) (King et al., 2007) reviewed research on LGBT-identity-affirmative therapy. No studies on affirmative therapy that were reviewed met the standards that the APA Report required of change-allowing therapy. The BACP still recommended affirmative therapy. The BACP review appeared to look at no research at all directed for traditionally religious clients who may reject an LGBT identity and who desire change-allowing therapy.

194. Several studies using randomised control trials, considered the gold standard, have found that LGB-identity-affirmative therapy that adapts standard therapy to gay culture was generally not more effective than standard therapy. Also, therapy that treated minority stress as a cause of mental health disparities in LGB-identified people was not more effective than not having the therapy. (Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Pachankis et al., 2015; Nyamathi et al., 2017; Pachankis et al., 2022; Pachankis et al., 2022)

a. **Researchers in a 2020 study said whether LGBT care "requires an explicit focus on minority stress as an etiological [causal] source of sexual minority women's mental and behavioural health remains unknown."** (Pachankis et al., 2020, p. 626).

[10] Personal communication with the Executive Director of the Alliance for Therapeutic Choice and Scientific Integrity, David Pruden, on July 9, 2020 confirmed these details.

b. **In another study, researchers suggested that their participants from an urban centre with supportive social organisations may not experience minority stress.** (Pachankis et al., 2015, p. 15) **If that is true, then the mental health disparities of these LGBT individuals were not caused by minority stress**.

c. **A further study found treatment for minority stress did not improve mental health in LGB-identified participants unless they were Black or Latino.** (Keefe et al., 2023, abstract).

d. **These studies taken together suggest minority stress may not be an adequate explanation for higher prevalence of mental health problems in LGB-identified people. There may be other causes that are being left unaddressed under the LGB-identity affirmative approach as expressed, for example, in the prohibitions of the MoU.** I will later discuss a nationally representative study conducted by the originator of the minority stress theory and colleagues which concluded it was the best available study and did not support the theory.

195. **With regard to treating gender dysphoria, the Finnish Recommendation attests that transgender-affirmative medical interventions are not effective for treating psychiatric disorders.** "Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." (2020, chapter 6) Several longitudinal, population-registry-based studies have found affirmative interventions for gender dysphoria were not effective for improving mental health. (Branstrom & Pachankis, 2020; Dhejne et al., 2011; Glintborg et al., 2023; Hisle-Gorman et al., 2021; Kaltiala, Hottinen, & Tuisky, 2023)

196. **The National LGBT 2017 Survey commissioned by the U.K. Government Equalities Office (GEO) is often referenced in support of a therapy ban. (GEO, July 2018, Summary Report; Research Report) A secondary analysis of the data raised concerning questions about the representativeness of the survey and about potentially socially biased effects of a therapy ban. (Sullins, 16 March 2024) The analysis points out that the survey data would inappropriately apply viewpoints of exclusively same-sex attracted, single, non-religious, White people to both-sex attracted people, ethnic groups, and adherents of the major religions of the world. The survey data is not representative of people who experience same-sex sexuality or gender discordance. It excludes by design non-LGBT-identified people, under-represents both-sex attracted people who are the majority of same-sex attracted people, under-represents their relationships, and would target Black people and people of the major world religions, especially Muslims and Hindus.**

197. **The survey boasts "over 100,000 LGBT people, making it one of the largest collections of empirical evidence from this group to date."** (GEO, July 2018, Research Report, p. 10) **The survey report acknowledges the survey is not, however, representative of LGBT-identified people in the U.K. It states:** (p. 10)

The dataset obtained from the survey represents a self-selected sample and is not representative of all LGBT people in the UK. In addition, respondents were willing to self-identity as LGBT and may be different from, or have different experiences to, people who do not wish to disclose their LGBT status, even in an anonymous survey. As such, findings reported here apply to the respondents to this survey and not to the general LGBT population.

a. **By surveying only people who adopt an LGBT identity, the survey excluded by design many, if not most, people who have same-sex attraction feelings or behaviours and is not representative of them, as is common practice in studies that challenge change-allowing therapy. (Examples: Ozanne, 2018; Blosnich et al., 2020)**

    i. **There are more people, by far, who experience same-sex *attraction* feelings than take an LGB *identity*. This is according to nationally representative data** in the U.K. Office of National Statistics (ONS) Annual Population Survey (APS). (Geary et al., 2018) Compared to men and women in Britain who had same sex *attraction*, only a little more than a third as many men took a gay or bisexual *identity* (38%), and only about a fifth as many women did so (21%), clear minorities. (More at section "V. Same-Sex Attraction, Behaviour, and Identity May Change Throughout the Lifespan") This phenomenon has been known since one of the earliest population representative studies in the U.S. (Lauman et al., 1994)

    ii. **As a result, this survey, as in the case of many studies that seek to challenge change-allowing therapy, may overrepresent people who hold the researchers' preferred LGBT-identity affirmative viewpoint that same-sex attraction or discordant gender identity feelings or behaviours are who a person is, that is, are their identity, and underrepresent people who do not share this view. (Rosik et al., 2021a, pp. 195-196, 198; Shaw et al., 2012, pp. 19-20)**

    iii. **The survey findings are being used to inform and justify banning therapy for people who were not permitted to be represented in the survey. It excluded people who have changed (they do not identify as LGBT) and the non-LGB-identified sub-population that typically has traditional religious values, a population that is most likely to experience change-allowing therapy and that finds most goals of change-allowing professional or pastoral counselling helpful.** (More research discussion about non-LGB-identified people at "XV. Growing Evidence that Researchers Who Report Harm and Researchers Who Report Benefit Are Studying Different Sub-Groups".)

b. **Both-sex attracted people constitute most same-sex attracted people, and they were underrepresented in the survey. Their relationships are mostly**

with the opposite sex, and they may need or want therapy to decrease their same-sex attraction or behaviour and enhance their heterosexual side to protect or enrich their marriage and family. They should have access to marital support as much as anyone else. The survey leaves the government with the false impression that most LGBT-identified people are exclusively attracted to the same sex (61%) and only a minority are both-sex attracted (25%). In reality, according to representative data collected by the U.K. Office of National Statistics (ONS) Annual Population Survey (APS), the majority of people in the U.K. who are not heterosexual are both-sex attracted (52%). Among ONS survey respondents generally, 54% were in a relationship and 44% were not. Also, young adults were over-represented in the GEO survey, with 69% of participants under age 35. (GEO, July 2018, Research Report, p. 15, "Key Findings"; Sullins 16 March 2024)

c. **The GEO survey summary report said, "We did not provide a definition of conversion therapy in the survey".** (GEO, July 2018, Summary Report, p. 14**) As a result, readers do not know what the survey studied.** Respondents were asked, "Who conducted your 'conversion' or 'reparative' therapy?" A respondent could have had in mind that they asked their pastor to pray with them once. A young person could have been remembering that their parents encouraged them to wait until age 18 before deciding on pursuing body altering gender medical interventions. Another person could have been calling to mind that their physician explained the research findings on the harms and benefits of gender medical interventions, and the patient felt the doctor was trying to discourage them from this path.

d. **The survey only asked participants "whether they had ever undergone or been offered any such intervention and, if so, who had conducted or offered it."** (GEO, July 2018, Research Report, p. 83) **Respondents were not asked whether it was helpful or harmful in any way. Therefore, the value of this survey in guiding a decision about access to professional or pastoral counselling is significantly limited.**

e. **Most of the options participants could select to indicate who gave them "conversion therapy" are not therapists at all. They are family members and people of the major religions of the UK and the world.** In fact, participants said 16% of "conversion therapy" was with a "parent, guardian or other family member", 19% said "healthcare provider or medical professional", and 51% said "faith organisation or group". Rates were similar for "Trans" identified at 14.8%, 15.2%, and 52.8% respectively. (GEO, July 2018, Research Report, pp. 93, 94)

f. **Muslims and Hindus would be the religious groups most affected by a therapy ban.** (GEO, July 2018, Research Report, p. 88; Sullins, 16 March 2024) I explained in my submission for the International Foundation for Therapeutic and Counselling Choice (IFTCC) for the public consultation on a proposed therapy ban in Scotland: (Haynes, 2 April 2024)

> While research on the non-LGB-identified population has largely studied people who identify as Christian, Catholic, Jewish, or Mormon, findings in the National LGBT 2017 Survey show that Hindus and Muslims will be the most affected by a therapy ban within the UK. [Sullins, 16 March 2024] A joint press release by the British Board of Scholars & Imams, the Muslim Council of Scotland (SCIO), & the Muslim Council of Wales announced the publication of "Conversion Therapy: What Should Muslims Know?" a pamphlet available online that provides guidance for Muslims and critical evaluation of therapy bans proposed in their regions. (Three Leading Muslim Organizations, [British Board of Scholars and Imams et al.,] 8 March 2024) The international Organization of Islamic Cooperation (OIC, 2016) said, "We believe that the concepts of sexual orientation and gender identity are not recognized under any international instruments, and run counter to the values and teachings of many religions and beliefs including Islam."….The OIC has 57 nation members and is the largest organisation of nations in the world next to the United Nations (OIC, no date) ….The OIC is the collective voice of the Muslim world.

g. **Respondents to the survey were overwhelmingly White at 92%** (p. 21) **and were non-religious at 69%** (p. 22). **According to the survey, Blacks are the race that most uses religious "conversion therapy".** (GEO, July 2018, Research Report, pp. 87, 91; Sullins, 16 March 2024) A secondary analysis of the survey data concluded: (Sullins, 16 March 2024, p. 10, bold added)

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

h. **The survey corroborated the Cass report on long waiting times for gender clinic access.** It reported LGBT identified people had **"**worse general health outcomes when compared to heterosexual people, including higher rates of mental health problems, attempted suicide, self-harm, anxiety, and depression. For trans men and trans women, long waiting times for referral to Gender Identity Clinics are seen to adversely affect mental health." (GEO, July 2018, Research Report, p. 161 "Overview", p. 162 "Key Findings", p. 178f

"Mental Health", p. 214 "Key Findings", p. 225 Table 9.5 ease of access, p. 227f respondent comments; Cass, 2022, p. 48)

198. **The Ozanne Foundation 2018 Faith & Sexuality Survey** (Ozanne, 2018) **has strongly opposed change-allowing therapy. The survey report said it "was designed to examine the role religious belief has on people's understanding and acceptance of their sexual orientation in the UK."** (p. 4) Questionnaire responses of 3,908 U.K. volunteers (p. 4) over-representing Anglicans and individuals who identify as gay and lesbian (pp. 7-9), were reported. **The bishop's foreword invalidly referred to same-sex sexuality as "innate," perhaps indicating something of the viewpoint of the organisers of this report.** The critique by the Science and Research Council of the International Federation [now Foundation] for Therapeutic and Counselling Choice (IFTCC et al., 2018) pointed out:

> **The NFSS documented that 13 respondents, even in this biased sample, reported they changed sexual orientation *completely* through therapy.** (IFTCC et al., 2018, p. 31)

a. **The report analysis ignored bisexuals, the second largest sexual preference group in the NFSS, known to be the most likely to change sexuality and change toward heterosexuality, and the most likely to desire assistance** to change to protect their opposite-sex marriages and their families. (IFTCC et al., 2018, p. 8)

b. Among participants, 60 said it worked for a while. That could help some hold their family together long enough to get their children raised, so it may have been experienced as worthwhile. (IFTCC et al., 2018, p. 31)

c. The NFSS cannot link mental health problems of LGB identified participants to change-allowing therapy.

    i. More NFSS respondents said they had mental health problems than said their mental health problems resulted from therapy. (IFTCC et al., 2018, p. 19)

    ii. The NFSS did not compare respondents' mental health problems before and after therapy. Therefore, it cannot say whether their mental health problems changed through therapy.

d. **This survey is not about children or youth as it claims.** It gathered no data on children, and only one-ninth of the respondents were ages 16 to 25. In fact, 72% of the participants were born before 1984. "Curiously, only 10 respondents gave any indication of the chronological year they attempted to change their sexuality," so attempts to change cannot be linked to experiences of children now. (IFTCC et al., 2018, pp. 24, 28).

e. **Implications that religious agents forced change efforts cannot be substantiated.** Participants were asked on separate questions whether they had been forced to undergo change efforts and who had forced them. While 82 participants said they were forced, amazingly 19 times that number said who had forced them. Obviously, this makes no sense. Participants were also asked in separate questions whether they had been advised to undergo change efforts and who had advised them. Regarding those who said they had been advised to try to change their sexuality, remarkably 3 times that many answered who advised them (IFTCC et al., 2018, pp. 25-26). These logical impossibilities render the results incoherent at best and uninterpretable.

f. **The NFSS is hardly a study of professional change-allowing therapy or counselling.** "Only a small minority sought advice from actual NHS or private medical professionals, such as their NHS GP (4.9%), NHS Psychiatrist (2.7%), or NHS Psychotherapist (3.3%)." (IFTCC et al., 2018, p. 22)

g. **It is impossible to know what change efforts the NFSS surveyed.** Question 28 would, for example allow someone to report a single occasion of private prayer as their attempt to change, and then, in response to Question 31, report that it did not work. (IFTCC et al., 2018, p. 31)

h. **Response options were biased and could well have created false impressions about contemporary change methods, thereby biasing participants' beliefs and responses.** Options for forms of change attempts someone may have used lumped together aversive medical interventions that ordinary mental health professionals and pastors could not conduct and that were abandoned long ago and private prayer with friends. Such associations may have biased participants against religion. (IFTCC et al., 2018, pp. 28-30) Options respondents could choose for why they desired to change their sexuality were limited and biased. No positive options were offered, such as reproductive health, happiness, fluidity exploration, dissatisfaction with same-sex experiences, desire to explore trauma felt to have led to same-sex sexuality and desire to bring healing, wanting to preserve one's marriage and family, desire to explore one's potential for a procreative relationship, or desire for fulfilment. (IFTCC et al., 2018, p. 27)

i. Differences in well-being for all groups (heterosexuals, lesbians and gays, those who tried changing sexuality, and those who did not try changing sexuality) were so tiny as to be meaningless. Differences between groups were fractions—.19 to .38—of 1 point on a 5-point scale. (Ozanne, 2018, p. 19)

j. **To the surprise of the NFSS researchers, participants who identified as "SSA" scored higher than all other groups on "Satisfaction with Spiritual Life". Individuals who identify as SSA (same-sex attracted) reject an LGBQ identity and are more likely to accept traditional religious beliefs that reject same-sex relationships. It appears that, rather than being driven to harms such as**

self-hate by their religious beliefs, they were the most spiritually flourishing. (Ozanne, 2018, p. 19)

k. **So, respondents' *opinions* on professional change-allowing conversations do not square with the *actual findings* of the survey.** "Amongst those who said that sexual orientation change therapy should be made a criminal offense, virtually all (98%) said that their reason for believing this was because it "damages mental health." A significant proportion (88.5%) also believed it "causes self-hate." (Ozanne, 2018, p. 18) Participants' own reported personal experiences did not support this view. (IFTCC critique, 2018, p. 35)

l. **Opinions on trying to change may have been influenced by cultural ideology of younger respondents**. "The desire to ban it was far stronger amongst the younger age groups." (Ozanne, 2018, p. 17) They are the least likely to have tried to change, given that the professional organisations banned each other from professional change-allowing conversations in the first version of the MoU in 2015. (IFTCC critique, p. 35)

m. **The bias in the NFSS questions may well have influenced participants' responses.** The IFTCC critique outlines,

> "The survey promoters want to criminalise therapy to change sexuality. They aimed to reach faith communities – especially Anglicans or LGBT networks. They found an older, mostly LGBQ and somewhat Anglican sample. This created participant selection bias. In addition, they did not elicit positive, happy reasons for wanting to attempt a change in sexuality, but likely drew a horrified response by telling participants about people forced and abhorrent practices (Q20, Q22, Q28) – without telling them that these are already abandoned. Then they asked if the respondent wanted all this made illegal. By offering only biased response options, the researchers communicated their negative views of change-allowing therapy. They thereby created a high risk for 'good subject' responses, that is, for participants to give responses they believe the researchers prefer that will confirm the researchers' views. (Nichols & Manor, 2008) The combined effect of participant selection bias and good subject bias is *confirmation bias*. This was admitted in the Director's Report: '*For many, much of this report will confirm what they already know regarding the dangers of 'conversion therapy.'*" (IFTCC critique, 2018, p. 30).

199. The Ozanne Foundation commissioned "The Cooper Report: Recommendations on Legislating Effectively for a Ban on Conversion Practices" by the "Ban 'Conversion Therapy' Forum" (October 2021). The Cooper Report, apparently written by lawyers, legislators, and activists but not professionals or researchers in the mental health services fields, appears to mirror the assumptions and mistakes of the MoU, hence the present expert report on the MoU suffices to address it. The Cooper Report rests largely on legal arguments, anecdotal evidence, and position statements

and erroneously claims the United Nations has a position on change-allowing therapy and has called for a therapy ban. (This common U.N. mistake is addressed after the Cooper Report.)

a. The Cooper Report does, however, reference 3 surveys to claim harm from "conversion therapy". These include the National Faith and Sexuality Survey (2018) by the Ozanne Foundation and the GEO National LGBT+ Survey (2018) that I have reviewed directly above in my report. Addressing therapy relevant to gender identity only, it also references the "Conversion Therapy and Gender Identity Survey" (2020) commissioned by the Ozanne Foundation to look "at the impact of Gender Identity 'Conversion Therapy' (GICT)". (p. 5) This survey was promoted by the advocacy groups GIRES, LGBT Foundation, Mermaids, Ozanne Foundation, and Stonewall (title page, pp. 7, 20) and, as a result, participants are skewed toward individuals who support the transgender identity affirming viewpoint of these organisations and underrepresents the views and experiences of people who do not take a transgender affirmative viewpoint toward their discordant gender identity. Despite the consequent biased sample of participants, the survey reports that some participants "may well have been people who had questioned their gender identity but ultimately went on to no longer experience dysphoria and so live as their gender assumed at birth. It is important to acknowledge that there was also a small number of respondents who went through gender identity 'conversion therapy' and believed it had successfully made them cis." (p. 8) Gender identity conversion therapy was defined to include an exceedingly wide variety of approaches mixed together under this same term. Most of the "therapy" was provided by family members and religious or spiritual leaders. (p. 11) The authors went on to say that gender diverse people who went to therapy (GICT) reported poorer mental health and more suicidal thoughts and attempts than people who did not go to therapy. Rigorous research has found, however, as previously presented at length in my report, that gender discordant individuals, especially adolescents, commonly have a high rate of serious psychiatric disorders before onset of gender discordance or dysphoria. (See section in my report: VII. Discordant Gender Identity May Have Treatable Psychological Causes) The survey did not measure prevalence of mental health problems before therapy versus after therapy and therefore could not rightly deduce whether the prevalence was greater, the same, or lower after therapy. The researchers made the invalid inference, anyway, that the therapy caused the higher prevalence of mental health and suicidality problems (pp. 2, 14) and called for banning it. This mistake is called the "fallacy of association" and is made regularly by studies that claim harm from sexuality or gender identity change efforts. It may be expected that people who have more mental health problems or suicidality go to any kind of therapy more than people who have fewer mental health problems or suicidality. When the before versus after therapy comparison has been made for individuals who identified as LGB, for example, in a nationally representative study, it has been found that the therapy did not increase and may have decreased suicidality and potentially other mental health problems, and dramatically so. (Sullins, 2023a, 2023b,

2022a, 2022b. See this finding and the fallacy of association explained at "XIII. Research that Claims Change-Allowing Therapy Is Harmful Is Fatally Flawed"). To their credit, the researchers acknowledged the survey is not "statistically robust quantitative data" (p. 2) and does not report prevalence of gender identity conversion therapy in the U.K. (p. 7)

b. **The Cooper Report (2021) was published before the Cass Report (2024). It evidences little awareness of peer-reviewed, quantitative, psychological research on a wide range of pertinent topics.** These include: (1) sexuality, gender identity, and gender dysphoria—social-psychological causes and change common throughout the lifespan, (2) the non-LGBT-identified population that is largely omitted from the report and will be most affected by it, (3) the harms of medical gender affirming interventions the Cooper Report supports and robust research finding the research in support of these body-harming interventions is remarkably weak, (4) fatal flaws regularly made in surveys claiming harm from change efforts as in the surveys that the Cooper Report references, and (5) research on therapy that the report opposes that has decreased distress and suicidality, improved self-esteem and well-being, and, in some cases, decreased or changed same-sex attraction or behaviour or discordant gender identity.

c. The Cooper Report may be the most extreme scheme for legally banning therapy that has been proposed. It calls for a comprehensive ban, even banning individuals who want and initiate receiving pastoral prayer from obtaining it. This despite the Conversion Therapy and Gender Identity survey, on which the Cooper Report relies, reporting that "some people may feel little impact" from private prayer and talk therapy, and some may feel the experience is "traumatic". ("Conversion Therapy" and Gender Identity Survey, 2020, p. 13) **It is likewise the case that some people experience affirmative therapy as unhelpful** (Nicolosi, Byrd, & Potts, 2000, p. 1082; Throckmorton & Welton, 2005; British Board of Scholars and Imams, et al., 2024) **and even traumatic with long-lasting harm** (IFTCC, 2024; British Board of Scholars and Imams et al., March 2024) **to the point that some same-sex attracted people will not go to affirmative therapy even when they are suicidal** (IFTCC, 2024). **Are the authors of the Cooper Report prepared to call for a comprehensive ban on affirmative therapy so that no harm may come? Is not a more proportionate solution offering training to pastors and therapists? The International Foundation for Therapeutic and Counselling Choice (IFTCC.org) provides training for pastors and therapists in ethical care that is culturally appropriate for people of traditional preferences, beliefs, values, and goals. I believe we can all agree in denouncing abuse, a primary focus in the Cooper Report. If it occurs in the U.K., it is already rightly illegal. Can we also agree that *all* people who experience same-sex sexuality or discordant gender identity should have the same right to support as everyone else** to protect their health, to treat a recognized psychiatric disorder such as compulsive sexual behaviour, to protect their private life as they see fit, to protect their marriage and family, and to live consistently with their religion that gives them

joy and should be respected? The Cooper Report would effectively deny this support to people who experience same-sex sexuality or discordant gender identity and do not share the viewpoint of the Cooper Report**. The authors of the Cooper Report appear unaware of the existence of other genuinely different minds that prefer to be outside the LGBT-identity-affirming community. It appears they cannot grasp, believe, or accept that they actually exist, and they appear to regard them as a threat to their own viewpoints. Inadvertently, their legislative scheme will do to non-LGBT-identified people what they themselves abhor. This is what the MoU also does.**

200. It is sometimes falsely inferred that the United Nations has taken a position in opposition to change-allowing therapy. The Ozanne Foundation's Cooper Report, for example, made this mistake. A report by a volunteer "independent expert" individual, (OHCHR, 2020) submitted to the Human Rights Council (HRC) or a report of a High Commissioner of the HRC (UN HRC, 2015) does not represent the views of the United Nations. Neither the Human Rights Council nor the United Nations has ever considered any of these reports or proposals. U.N. Member States, many in fact, have said they do not recognise the independent expert's mandate to submit reports. (Example of 57 nations: OIC/CFM-43, 2016, p. 68; see OIC, n.d.) In fact, little agreement exists among U.N. nations on issues of sexual orientation and gender identity. Rather, the U.N.'s human rights experts are closely aligned with the priorities of rich donor countries that fund these experts and then quote their reports to support agendas. (Oas, 2022) There is no United Nations binding treaty that mentions therapy for managing, decreasing, or changing sexuality or gender identity. The Human Rights Council explains that independent experts "work on a voluntary basis; they are not UN staff and do not receive a salary for their work. They are independent from any government or organization and serve in their individual capacity." The International Federation [now Foundation] for Therapeutic and Counselling Choice that now serves professionals in more than 30 nations sent a submission to an "independent expert". (IFTCC, Science and Research Council, 2019) He has never contacted the IFTCC to learn more about what ethical principles and practices the IFTCC does and does not support in professional therapy or counselling or pastoral counselling for individuals who feel distressed by their sexuality or gender identity and who desire therapy that decreases this distress and may or may not result in decrease or change in these undesired experiences. We believe his report was significantly incomplete and biased.

201. A poll that, unlike the Ozanne Foundation's National Faith and Sexuality Survey, actually was representative of the U.K. population, conducted by ComRes for Core Issues Trust in 2014, found "42% said they would oppose a ban on talking therapy to reduce same-sex attraction, 24% would support a ban" and "64% of respondents said talking therapy to reduce SSA and keep a family together should be allowed. Significantly, 43% of the 18- to 24-year-olds in this ComRes study said they would oppose a ban—a stark contrast to the responses of the same age group in the NFSS." (IFTCC et al., 2018, p. 35)

202. **In 2023, Pollsters Whitehouse Insight reported that a significant poll of 2,091 voters found that a "conversion therapy" ban is not a priority for 96% of voters.** The pollsters said, "Despite years of campaigning by activists, the public are not at all convinced of the need for an expansive conversion therapy ban." (Christian Institute, 2023)

203. **A nationally representative poll of Canadian adults found 91% support consenting adults being free to get the sexuality counselling of their choice, regardless of their sexual orientation or gender identity. (Nanos, 2021)**

204. **I have worked together with therapists and counsellors from around the world who support therapy and counselling conversations** that decrease this distress and may lead to these reductions or changes in sexual or gender feelings or behaviours and who oppose therapy censorship. **Claims to the contrary notwithstanding, there is not a professional consensus in opposition to such therapy.**

205. **There is not a scientific basis on which to censor change-allowing therapy, and misrepresentations to the contrary are harmful.** Some who decreased distress and modified or changed their sexual or gender feelings or behaviours as an outcome of therapy regret the years they lost that they could have lived the way they do now, because their family and cultural pressure led them to believe they could not and should not engage in therapy conversations wherein distress from sexuality or gender identity decreases, well-being improves, and these traits may or may not change.

XIII. RESEARCH THAT CLAIMS CHANGE EXPLORING THERAPY IS HARMFUL IS FATALLY FLAWED

206. **Opposition to change-allowing therapy has focused largely on claims of harm. There is, however, no research that meets scientific standards that substantiates disproportionate harm** from professional, noncoercive, nonaversive, client-initiated and client-directed therapy conversations using evidence-based methods and well-established practices therapists use around the world. **Studies claiming to have found disproportionate harm have employed biased methods.**

207. **In the first nationally representative study to claim harm from "sexual orientation change efforts" (SOCE) (Blosnich et al., 2020), the researchers made a fatal mistake. When the mistake was corrected, the results were flipped. The study showed SOCE did not increase suicidality and may have reduced it, potentially dramatically. (Sullins 2022a; 2022b; 2023) Researchers who have claimed SOCE harm, like these, have regularly violated the scientific principle that a cause must precede an effect. This principle would require researchers to find out whether suicidality rates after change-allowing counselling were higher, the same, or lower than rates prior to such counselling before claiming change-efforts cause suicidality. Blosnich and colleagues had not done that.** (Rosik, 2022; Sullins, 2022b)

a. **Sullins (2022b) replicated the nationally representative study by Blosnich and colleagues (2020)** that used "data from the Generations study, a well-crafted

survey of a statistically representative sample (N=1518) of the LGB identified population in the United States administered by the Williams Institute in 2016 and 2018 (Meyer et al., 2020)" at the law school of the University of California at Los Angles. The lead author in crafting the Generations data set was the originator of the minority stress theory.

b. **Blosnich and colleagues said studies of "SOCE" (sexual orientation change efforts) previous to theirs had been "qualitative" or "anecdotal", and, to their knowledge, theirs was the first "nationally representative sample of non-transgender sexual minorities in the United States." (2020, p. 1027) This means findings from previous U.S. surveys that claimed SOCE harm might not have represented experiences of all LGB-identified people.**

c. **Blosnich and colleagues had the data available to compare measures of suicidality both before and after SOCE and chose not to use it.** They used only *lifetime* measures of suicidality that combined both before and after SOCE suicidality. Then they said SOCE "may compound or create…suicidal ideation and suicide attempts" and suggested it "is a stressor with particularly insidious associations with suicide risk." (2020, p. 1028)

d. **Sullins corrected their methodological error by using the data that Blosnich and colleagues had but chose not to use.** Sullins dug deeper into the data set and found it included not only whether participants had ever in their lifetime experienced SOCE or suicidality (suicidal thoughts, plans, intent, or attempts), but also the age at which they experienced each of these. It was therefore possible to determine whether SOCE or suicidality came first.

e. **Sullins (2022b) discovered, "Most of the suicidality did not follow change-allowing therapy in time but preceded it." (p. 3386) He found, "Minors undergoing SOCE were only about half as likely to attempt suicide after initial thoughts or plans of suicide, and no less likely after an initial suicide attempt, compared to their peers who did not undergo SOCE. On the other hand, adults who experienced SOCE intervention following suicidal thoughts or plans" were dramatically less likely to attempt suicide, up to 17 to 25 times less likely (p. 3387) if one assumed SOCE on average lasted 1 to 2 years (p. 3378). Even if one assumed SOCE on average lasted 4 or 6 years, Sullins found SOCE still did not increase suicidality and may have decreased it. (Sullins, 2023a) Unsurprisingly, people who were suicidal went for counselling more than people who were not suicidal. The counselling decreased their suicidality.**

f. **Sullins' reanalysis (2022b) that compared before and after SOCE suicidality has been regarded as a significant paper** as evidenced by the fact that it was published in the highly regarded journal, *Archives of Sexual Behavior,* and elicited several comment articles also published in that journal to which he has published a strong combined rejoinder (Sullins, 2023a) and another rejoinder (Sullins, 2023b)

g. **Responding to criticisms in comment articles, Sullins refined his reanalyses. Sullins came to the same conclusion** when he reanalysed the original data set (Meyer et al., 2020) using different approaches (regression models or counterfactual matching models), and whether he assumed SOCE lasted 1-2, 4, or even 6 years, namely that "exposure to SOCE does not increase suicide risk, and may even reduce it." (Sullins, 2023a, pp. 889-895)

h. **Sullins' findings (2022a, 2022b, 2023) may underestimate the benefit of SOCE, since people who may have successfully changed sexual identity and no longer identify as LGB "were systematically screened from the survey sample**, which only included those currently identifying as sexual minority." (2022b, p. 3387, bold added) If formerly LGB-identified people who changed through SOCE had been included, they likely would have said they benefitted from SOCE.

i. Because Sullins (2022b, 2023a) used a nationally representative study of people who continued to identify as LGB, **the generalisation can rightly be made that change-allowing therapy does not increase suicidality and may actually reduce suicidality for people who do not change through therapy. This contradicts the claim that not changing through SOCE makes people suicidal. Rather, change-allowing counselling has many benefits, even for people who do not change.**

j. **In an earlier published replication study of Blosnich et al (2020) based on the same data set, Sullins (2022a) had looked at rates of harmful behaviour in the past 12 months rather than looking at before and after SOCE rates. To Sullins' knowledge, this was the first time these *harmful behaviour* rates were studied on a nationally representative sample of LGB-identified people who reported they had experienced SOCE and who did not change** sexual attraction identity (they still identified as LGB). Sullins discovered that SOCE alumni had experienced "higher lifetime and current minority stress, greater childhood adversity, and lower socioeconomic status." (Abstract) He pointed out, "This group constituted not only a test, but a stress test of the hypothesis that SOCE therapy induces harm. If any group were likely to suffer harm from SOCE counselling, this group would have done so." (p. 9) Yet the study found that in the past 12 months, "Those who had undergone [failed] SOCE were no more likely to experience psychological distress or poor mental health, to engage in substance or alcohol abuse, to intentionally harm themselves, or to think about, plan, intend or attempt suicide, than were those who had not undergone SOCE." (p. 9) When Sullins controlled for the higher rates of minority stress, childhood adverse experiences and the lower socioeconomic status of SOCE alumni, he found suicidality rates for SOCE alumni were seen to decrease to 5 times lower. A rebuttal commentary (Meyer & Blosnich, 2022) pointed out that neither a correlation between lifetime suicidality and SOCE nor 12-month suicidality and SOCE can demonstrate whether SOCE causes harm, as Sullins agrees. It seems likely, however, that if Sullins had controlled both for these harmful behaviours and also for before

and after SOCE rates at the same time, the suicidality rates may have been even lower. Sullins concluded, "Concerns to restrict or ban SOCE due to elevated harm are unfounded." (2022a, abstract)

k. **Meyer and Blosnich conceded that SOCE is not persistently harmful,** agreeing that, in general, "… persons are not currently suicidal from a SOCE exposure that likely happened 10 or more years earlier." This was in a response to Sullins' study of past-year suicidality. (Meyer & Blosnich, 2022)

208. Related research by LGB-identity-affirmative researchers does not support a view that SOCE causes worsening of the psychological distress or suicidal attempts of LGB-identified people.

a. Sullins pointed out similar findings in another study. "Altogether, 88% of clients in Shidlo and Schroeder's sample who were suicidal before or during conversion therapy did not subsequently exhibit further suicidality, and only 5 persons (2.5% of total participants) without a previous history of suicidal attempts initiated such behaviour following conversion therapy. (Shidlo and Schroeder 2002, p. 254)" (Sullins, 2022b, p. 3388)

b. By contrast, while Meanley et al. (2020) "were studying older adults using decades of longitudinal data, they never considered the extent to which poor psychosocial health may have predated SOCE." (Sullins, 2022b, p. 3388)

c. Salway et al., who alleged strong psychological harm from SOCE solely from global associations, reported, 'We are unable to know whether SOCE preceded the psychosocial health outcomes identified by participants". (Salway et al., 2020, p. 6) Sullins challenged, "This is not true: their measures…would have given them a direct measure….it is likely that a substantial proportion of the reported suicidality preceded SOCE exposure." (Sullins, 2022b, p. 3389)

d. Blosnich et al. and Salway et al. "seem unaware, or perhaps they disagree, that to assume that an effect can precede a cause is not merely a theoretical disagreement that challenges their conclusions, but is a logical fallacy that undermines them altogether." (Sullins, 2022b, p. 3389)

e. Ryan et al. (2020), a study that is often cited to claim SOCE harms minors, committed the same fallacy of association, as Sullins pointed out. (2022b, p. 3388)

209. Sullins pointed out that the serious harm coming from the fallacy-of-association flawed logic is that efforts are being made to ban a potential treatment for suicidality (Sullins, 2022. P. 20), saying,

> 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.

210. "The four recent studies employing the fallacy of association discussed above, by Salway et al. (2020), Blosnich et al. (2020), Ryan et al. (2020), and Meanley et al. (2020), comprise the most frequently cited population evidence for the conclusion that SOCE therapy increases the risk of suicidal behavior," as Sullins (2022b) outlines.

211. The study by Ryan et al. (2020), which is one of the studies used to claim change-allowing therapy or counselling is potentially harmful and contributes to depression and suicidal thoughts and attempts in minors, is a model of the problems regularly found in research purporting to show harm. It was conducted by an LGBT-identity-specific organisation. This small study near San Francisco looked at only *parent*-initiated efforts by surveying young adults (ages 21 to 25) who currently frequent LGBT bars and agencies and asked about their adolescent experiences concerning "conversion therapy".

a. This study looked only at parent-initiated change-allowing therapy. Ethical change-allowing therapists do not conduct parent-initiated therapy with adolescents, so this study does not apply to them.

b. The survey did not study client-initiated therapy at all. It has nothing to say about it. The very title of the article says it is about "Parent-Initiated Sexual Orientation Change Efforts". The authors reported there were six respondents who said they experienced SOCE that was not parent initiated, and Ryan et al. reported they excluded them from the study.

c. By research *design*, the study also excluded individuals who may have changed through SOCE. Researchers solicited participants *only* from LGBT-supportive venues, and people who have changed LGBT feelings or behaviours do not generally frequent LGBT-supportive venues. Individuals who changed would likely report benefit and safety.

d. Hence, by research design, participant selection was biased. The study researched change-allowing therapy safety by studying only LGBT-identified participants. As Rosik has said, this would be like surveying only or largely people in a divorce support group (Rosik, 2022) to find out whether marital therapy is safe or effective. There was no comparison group, and the study relied on self-reports of adults in the LGBT-identity community who may have

had a political interest in portraying change-allowing therapy as potentially unhelpful or harmful.

e. "Conversion therapy" was ill-defined and was not only applied to therapists or counsellors. Researchers also included religious leaders and even parents as providing conversion "therapy". The definition for what constitutes "conversion therapy" was vague, nor was it clear if any such therapy was conducted by licensed professionally trained therapists using nonaversive, noncoercive, contemporary, evidence-based methods and well-established standard practices. Thus, we do not know what was studied.

f. Similarly to the Ryan et al. study (2020), other studies also have looked at participants largely or solely coming from LGBT-identity supportive organisations or communities (Blosnich et al., 2020; Green et al., 2020; Turban et al, 2019; Flentje et al., 2014, Mallory et al., 2018; 2019; Maccio, 2011; Shidlo & Schroeder, 2002; Schroeder & Shidlo, 2001)

g. **A number of other studies have inter-mixed other kinds of change efforts with mental health professional psychotherapy or counselling as Ryan et al. (2020) did** (Ozanne, 2018; Blosnich et al., 2020; Green et al., 2020; Turban et al., 2019; Flentje et al., 2014; Dehlin, 2014; Shidlo & Schroeder, 2002; Schroeder & Shidlo, 2001), mixed interventions by medical and mental health professionals (Mallory et al., 2018; 2019), or studied only non-professional services, some of which did not offer to help people change, and then drew conclusions for professional clinicians (Maccio, 2011).

h. **Researchers revealed their viewpoints to participants.**

    i. **Biased and pejorative questions** have been given to participants, such as questions that asked whether anyone ever "tried to make you", "tried to change you", or "tried to stop you", "tried to convince them" implying coercion must have been used (Ozanne, 2018; Blosnich et al., 2020; Ryan et al, 2020; Turban et al., 2019; Green et al., 2020). Biased presentation of questions may, in itself, influence participants' views.

    ii. **Green and colleagues disqualified 105 participants who said they experienced change-allowing therapy, but it was not coercive therapy (someone did not attempt to "make" them change their sexual orientation or gender identity), apparently disagreeing with the biased presentation of change efforts in the questions. Researchers justified excluding them** by saying, "It was assumed that these young people may not have understood the intended meaning of conversion or reparative therapy." Excluding these participants may have added to participant selection bias. (Green et al., 2020, p. 1222)

    iii. **Also, researchers revealed their viewpoint to participants in an additional way.** Before questions on this same survey that were

specific to mental health or suicidality, participants were directed to contact the Trevor Project if needed. This means participants were told that the researchers were at minimum aligned with the Trevor Project. (Actually, the Trevor Project conducted the survey.) Therefore, the researchers communicated their viewpoint to the participants, thereby creating high risk for "good subject" or good participant bias, meaning they may have influenced participants to give responses they believed the researchers preferred. (Nichols & Maner, 2008) The Trevor Project notably started the campaign to ban change-allowing therapy in California in 2012 and actively continues the campaign to this day. Its position is well known in the LGBT-identity community from which participants were solicited.

212. Some researchers offered a biased scale for rating SOCE interventions that consisted largely (Dehlin et al., 2014; 2015) **or solely** (NFSS, 2018) **of negative options from which to choose.** Such biased research questions are likely to elicit responses that confirm the researchers' preferred outcomes. This source of bias was one of the several difficulties in three studies from the same sample of Mormons. (Bradshaw et al., 2015; Dehlin et al., 2015a; 2015b) Although the researchers attempted to include religiously observant people, the participants were largely religiously unaffiliated. Most participants were "gay" or "lesbian" identified, hence had not changed, and bisexuals were underrepresented, the identity most likely to experience change. The primary question asked participants to rate their experience of change efforts on a scale that offered 3 negative options, 2 positive options, and no neutral options. The question also invalidly mixed effectiveness and harm on the same scale. Nevertheless, as Sullins summarizes, benefits were found. "Dehlin et al. (2015b) reported that '[t]he SOCE methods most frequently rated as effective were support groups, group retreats, psychotherapy, psychiatry, and group therapy.' Thirty-nine to 48 percent of persons undergoing these methods rated them to be effective; 11 to 24 percent rated them 'highly effective' (p. 100). Overall, at least a fifth of participants rated every SOCE method in the study as either 'effective' or 'highly effective' (p. 100)." The researchers reported that "a small minority of persons self-assessed change in sexual orientation; that a higher proportion of persons did not perceive any change; that many of those who did not change sexual orientation attraction reported other benefits from SOCE; and that more persons reported benefit than harm. Pertinent to the present exchange, Bradshaw et al. (2015) found that a very small proportion (0.4%) of those receiving SOCE psychotherapy reported a suicide attempt, but over three times as many (1.3%) reported that SOCE helped them avoid suicide (p. 407)." In addition, "42% of Dehlin's (2015a) sample—reported that they were helped by the SOCE experience to reconcile or manage their conflicting sexual attractions and religious convictions in various ways." (Sullins, 2023a, p. 896) All of the 14 men in opposite-sex marriages reported they benefitted from support, and at least 78% reported same-sex attraction or behaviour reduction, opposite-sex attraction increase, or reduction in cross-dressing. (Bradshaw et al., 2015. Table 4 gives their comments.)

213. A study by Turban and colleagues (2019) claimed to be the *first* to examine harms from "gender identity change efforts," *thereby admitting claims of harm had*

had no basis in research that met scientific standards. This survey of gender-identity change efforts (GICE) followed the errant pattern of the sexual orientation change efforts (SOCE) studies.

a. Although it used a large number of participants, it incorporated the same kind of fatal flaw as the Ryan et al. (2020) study, namely using a convenience sample of only self-selected participants from only transgender-identity specific organisations. Gender discordant people who did not take a transgender identity and people who may have come to identify with their sex and benefited were omitted by design.

b. Researchers asked their primary question in a pejorative and leading way, thereby making their bias clear to participants. They asked, "Did any professional (such as a psychologist, counsellor, or religious advisor) try to *make you* identify only with your sex assigned at birth (in other words, *try to stop you* being trans?" (Emphasis added). Ethical change-allowing therapists and counsellors do not try to "make" anyone change, because they are committed to client self-determination. **The wording in this key question is a sleight of hand, changing a survey purportedly on GICE to a study of coercive efforts,** implying without being explicit and without evidence that these efforts are all coercive.

c. By stating questions in way that was pejorative to GICE, the researchers communicated to participants the negative views of the researchers toward GICE and likely the preferred responses. This methodology created a high risk for the "good subject" effect, that is, a high risk that participants would be influenced to give responses that they believed the researchers preferred and that would confirm the apparent views of the researchers. (Nichols & Maner, 2008)

d. This key research question mixed interventions of "a psychologist, counsellor, or religious advisor". Therefore, we do not know what was researched, whether survey respondents were reporting that a pastor prayed with them once in response to their request or they experienced client-initiated, client-directed, non-aversive, noncoercive, professional therapy of reasonable length using evidence-based therapy methods and well-established practices professionals use around the world.

e. Researchers inferred "from an association between psychiatric conditions (examples: depression, anxiety, suicidal attempts) and 'GICE' [gender identity change efforts] that GICE caused these conditions and ignored the possibilities that these conditions existed before the transgender identity or before GICE or that therapists did not affirm transgender identity in patients they diagnosed as severely mentally ill." (Haynes, L., 2021; see also Regnerus, 2019)

f. **Suicidality commonly *precedes* both SOCE and GICE in time. Researchers cannot just assume that gender change-allowing therapy causes the**

presence of psychiatric disorders or suicidality given the evidence that psychiatric disorders and suicidality commonly *precede* gender incongruence and gender dysphoria in time, therefore also precede gender change-allowing therapy in time. Researchers would have to compare data on rates of psychiatric disorders or suicidality *before* and *after* therapy to demonstrate whether gender change-allowing therapy leads to worse, unchanged, or better mental health. (See critical commentary by D'Angelo et al., 2020)

214. The following all rely on these harm-claiming studies that employ the fallacy of association: (1) The American Psychological Association's position statements in opposition to SOCE (2021) and GICE (2021), (2) a research review by Judith Glassgold, who formerly chaired the APA task force report (2009), in a 2022 edited book (Haldeman, Ed., *The Case Against Conversion Therapy* published by the American Psychological Association with its disclaimer on the copyright page), (3) the report of the team of scholars at Coventry University headed by Jowett and commissioned by the British National Equalities Office (Jowett et al., 2021; critiqued in Sullins, 2022b), (4) the report for Gov.UK, 2021, (5) the report of the team of scholars at Trinity University commissioned by the Irish government (Keogh et al., 2023), and (6) the Standards of Care for the Health of Transgender and Gender Diverse People, published by the World Professional Association for Transgender Health, Version 8 (Coleman et al., 2022).

XIV. MORE REASONS WHY IT CANNOT SIMPLY BE ASSUMED THAT CHANGE-ALLOWING THERAPY FOR UNDESIRED SAME-SEX SEXUALITY OR GENDER DISCORDANCE CAUSES SUICIDALITY OR SUICIDES.

215. Research has found that change-allowing therapy reduces suicidality (Sullins & Rosik, 2024), even for people who do not change same sex attraction. (Sullins, 2023a; 2023b; 2022; discussed immediately above at "XIII. Research That Claims Change Exploring Therapy Is Harmful Is Fatally Flawed)

216. Many potential risk factors for suicidality (thoughts, plans, attempts) and suicide in LGBT-identified individuals have been identified.

a. Childhood sexual abuse (McLaughlin et al., 2012; Eskin et al., 2005; Bedi et al., 2011; Fuller-Thomson et al., 2016)
b. Forced to have sexual acts (Clements-Nolle et al., 2001; CDCb, 27 Jan 2023)
c. Experienced physical, emotional, or sexual dating violence (CDCb, 27 Jan 2023)
d. Prevalence of substance abuse disorder, drug use disorder, alcohol use disorder (females), opioid use disorder (bisexual females) (SAMHSA, 2023)
e. Mental illness diagnosis or psychiatric disorders or behavioural or emotional problems (Ream, 2019; de Graaf, et al., 2020; Fergusson et al., 1999; Haas et al., 2011; SAMHSA, 2023 in addition to many more studies reporting internationally higher prevalence of psychiatric disorders)
f. Psychiatric drugs in the bloodstream (Ream, 2019)
g. Childhood family breakup (Fergusson et al., 1999; Francis, 2008; Udry & Chantala, 2005)

h. Family problem (Ream, 2019)
i. Intimate partner problem (Ream, 2019; Skerrett et al., 2017, CDCb 27 Jan 2023)
j. Relationship status (Turban et al., 2020, Table 2 caption)
k. Bullying (Kaltiala-Heino et al., 2015)
l. Genetic predisposition to depression (Ganna, 2019a; 2019b; Zietsch et al., 2012)

217. Since suicide risk factors have been found to be much higher for LGBT-identifying individuals *irrespective of therapy* and to *precede thoughts about gender*, one cannot simply presume therapy is to blame. Research claiming harm regularly fails to take into account the evidence for exceedingly high prevalence of psychiatric disorders, suicidal thoughts, and trauma such as from bullying *prior to onset* of thoughts about gender, hence certainly prior to affirmative or change-allowing therapy for thoughts about gender. Counselling conversations that explore a client's potential for resolution of gender dysphoria cannot possibly cause these high rates of suicide risk factors that precede thoughts about gender.

218. There is no research that compares suicidality or completed suicides of people who have had affirmative therapy, change-allowing therapy, or any therapy in general. It is likely that individuals who have sought *any* kind of therapy have had higher suicidality or suicide rates than individuals who have not sought therapy. Nationwide in the U.S., one-third of LGBT identified adolescents and young adults who committed suicide were in some kind of treatment for mental illness, according to findings of a large, national, psychological autopsy study. (Ream, 2019).

219. According to entire nationwide registry data in liberal, transgender-accepting societies, Individuals who have had *medical gender-affirmative* interventions generally have completed suicide at higher rates compared to the general population in the Netherlands (Asscheman et al., 2011; Wiepjes et al., 2020) and Sweden (Dhejne et al., 2011; NBHW, 2020) and compared to nontransgender people in Denmark (Erlangsen et al., 2023). A study in Finland was inconsistent with these findings. (Ruuska et al., 2024; results interpretation correction: Sullins, 16 March 2024).

220. One of the main arguments for censoring change-allowing therapy has been a claim that the very viewpoint that some people desire, feel they need, or benefit from change-allowing therapy causes minority stress and the higher rates of mental health disorders and suicidality among LGB-identified individuals, but that an affirmative societal viewpoint and banning change exploring therapy decreases the higher rates of psychological problems and suicidality in LGB-identified individuals. The originator of the minority stress theory and colleagues have said, "Minority stress theory predicts that health of sexual minorities is predicated on the social environment." (Meyer et al., 2021, abstract)

a. **Yet the originator of the minority stress theory, Ilan Meyer, and co-researchers (2021) found that, in the U.S., over 50 years—of dramatically and**

progressively increasing societal affirmation of LGB-identified individuals and earlier onset of coming out and sexual relationships, and they could have added increasing availability of LGB-identity-affirmative psychotherapy and discouraging of change-allowing therapy—the psychological stress, reported experiences of physical violence, and suicidality of LGB-identified people have progressively worsened.

i. Meyer et al. (2021) used the same elegantly designed Generations data set (Meyer, 2020) as Blosnich and colleagues (2020) and Sullins (2023a; 2023b, 2022a) used. Meyer and colleagues said their study of the minority stress theory was the *first* in the U.S. to use a nationally representative sample, a large-scale study, and questions and measures specific to this population. They thereby acknowledged that previous research on the minority stress theory did not use these methods and was not representative of the U.S. LGB-identity population. They concluded their findings did not support the minority stress theory. (Meyer, et al., 2021)

ii. The study did not explore further information from participants about experiences of violence or consider a variety of possible explanations besides the minority stress theory.

iii. **The study did not consider evidence suggesting, for example, that increase in early sexual activity with the likely accompanying increase in numbers of sexual partners may itself be an increased risk factor in early and late adolescent or young adult experiences of depression, suicidality, and violence.** A comprehensive, nationally representative study conducted by the U.S. Centers for Disease Control and Prevention (CDC) found that high school students, whatever their sexual orientation identity, who had no sexual contact were far less likely to feel sad or hopeless for 2 weeks in a row, to seriously consider, plan, or attempt suicide, or to be a victim of bullying, forced sexual intercourse, or sexual or physical violence by anyone or by a date, or to engage in behaviours that contribute to violence (carry a weapon or gun or be in a physical fight). Concerningly, the CDC study found experiences of physical and sexual victimization were higher in sexually active adolescents and especially within same-sex dating relationships. (Kann, McManus, & Harris, 2018) This study cannot tell us the direction or causation, whether (1) experiences in being sexually active lead to increased depression, suicidality, and violence, (2) depression, suicidality, and experience of violence lead to increased sexual activity, (3) something else leads to increased depression, suicidality, violence, and sexual activity among adolescents, or (4) some combination of the above.

iv. **The existence of change-allowing therapy is not a likely cause of the increasing psychological distress, suicidality, or experiences of**

violence of LGB-identified people. This study (Meyer et al., 2021) found that the percent of LGB-identified people who reported experiencing sexual orientation change efforts has not increased over 50 years. It has remained at 6% to 8% across the generations of LGB identified people in the past half century with no significant differences (correcting estimates by others that were not based on representative data; Rosik, 2020b). Since the existence of change-allowing therapy among LGB-identified people has not changed, change-allowing therapy could not have caused their increases in psychological stress and suicidality.

b. **The very same Generations data set of LGB-identified people (Meyer, 2020) revealed that (1) 50 years of dramatically progressive affirmation in the U.S. has been associated with progressively increased psychological distress and worsened suicidality for LGB-identified people (Meyer et al., 2021), but, by contrast, (2) experience of sexual orientation change efforts led to no increase in suicidality or led to decreased suicidality, potentially dramatically decreased suicidality (Sullins, 2023a, 2023b, 2022) and no increase in other mental health harm (Sullins, 2022) for LGB-identified people who did not change sexual attraction through SOCE. To draw another comparison, dramatically increased LGB-identity affirmation in society and psychotherapy for 50 years has denied potentially underlying causes of LGB-identity and not treated for them, while prospective, longitudinal studies have found that change-affirming therapy (Pela & Sutton, 2021) and religiously mediated support groups (Jones & Yarhouse, 2011) have addressed these with the overall outcome of improved mental health.**

c. **A large, prospective, longitudinal, nationally representative study in the Netherlands also did not support the minority stress theory as an explanation for the higher rates of psychiatric disorders in same-sex-attracted or active people.** The Netherlands became the first country to legalize same-sex marriage in 2001**.** The researchers reported, **"**Although we expected that disparities in rates of psychiatric disorders between homosexual and heterosexual persons would have decreased, as acceptance of homosexuality in Dutch society had increased, this was not supported." (Sandfort et al., 2014, p. 7)

d. **More research suggests that mental health disparities in people who have experiences of same-sex sexuality are not simply caused by societal discrimination. A large, Australian community twin registry study was notably able to look at both genetic and life experience factors in nonheterosexual preference and depression. The findings "suggest that genetic factors, childhood sexual abuse, and risky family environment are all involved in the elevated rate of depression in nonheterosexuals"**, **as well as other factors that one twin, but not the other, experienced. (Zietsch et al., 2012)**

i. This twin study found inherited genes accounted for 31% of the difference between people as a group who reported nonheterosexual preference versus people as a group who reported heterosexual preference. This is virtually identical to the 32% found in the largest-ever gene study (Ganna et al., 2019a) and the largest-ever twin study (Polderman et al., 2015, which may have used data from this Australian twin registry).

ii. **The study found there was a higher prevalence of depression for individuals of nonheterosexual than heterosexual preference. Factors associated with this higher correlation between nonheterosexual preference and depression were 44% genetic.** (p. 8) Depression was defined as the lifetime prevalence of depressive episodes that lasted for at least 2 weeks. The researchers said, "The elevated rates of depression in *heterosexuals* with a nonheterosexual co-twin suggest that familial factors not directly associated with nonheterosexuality also contribute to elevated depression rates in nonheterosexuals" (p. 9), and these may be genetic or social factors. The prevalence of depression in males and females was lower for heterosexuals at 24% and 37% respectively than for nonheterosexuals at 53% and 70% respectively.

iii. **It also found that, in nonheterosexuals who experienced depression, there were *common* factors that led to *both* nonheterosexual preference *and* depression, and 60% of these common factors were genetic.**

iv. **The remaining 40% of *common* factors for the origin of *both* same-sex preference *and* depression included experiences between the ages of 6 and 14 that contributed rates of about 8% (7.7%) for risky family environment, 9% (8.5%) for sexual abuse, or about 14% (13.7%) for a combination** of risky family environment and sexual abuse (suggesting there was an overlap of impact from these experiences when a child experienced both kinds). (pp. 7-8, 9) These percentages do not tell us the rates at which risky family environment and sexual abuse contribute to same-sex sexuality in nonheterosexuals in general (in both nonheterosexuals who experience depression and those who do not).

v. **Risky family environment was counted if a participant reported experiencing at least one of the following between the ages of 6 and 13: (p. 4)**

    1. **They would often have had an unpleasant disagreement with one or both of the parents.**
    2. **They were not at all close with their parents.**

3. **Their parents were often fighting or arguing in front of respondent.**
4. **There was a lot of tension between the respondent's parents in the household.**
5. **One of the parents drank too much.**

vi. Researchers said, **"**We examined whether a particular item in the risky family environment variable was driving the effect, but **each individual item was significantly associated with sexual orientation."** (p. 7)

vii. Childhood sexual abuse was counted if a participant reported any of the following was present. (pp. 5-6)

1. **The respondent reported having sexual contact (defined as 'their touching your sexual parts, your touching their sexual parts, or sexual intercourse') with an adult family member before the age of 14, or nonconsensual sexual contact with another child in the family.**
2. **A respondent reported being forced into sexual intercourse or any other form of sexual activity before the age of 14.**
3. **A respondent reported to have been raped or sexually molested before the age of 14.**
4. **A respondent reported to have had nonconsensual sex with someone 5 years or more older before the age of 14.**

viii. "Childhood sexual abuse took place at an average age of 8.7 years, well before the average age that sexual feelings developed" at 13.5 years. Perpetrators were male for 94% of males and 98% of females. (p. 5)

ix. "No significant effects were found for parental physical abuse, maternal or paternal age, or number of older brothers". (p. 7)

x. The genetic and childhood experiences assessed, taken together, add up to nearly three-quarters (potentially 73.7%) of the factors in common accounting for the co-occurrence of nonheterosexual preference and depression.

xi. Notably, the nongenetic common factors this study investigated narrowly included only experiences between the ages of 6 and 14, and then only experiences of risky family environment and sexual abuse.

xii. Not included were experiences up through age 5, commonly considered the most formative years of life, and experiences during adolescence from age 14 and on, also important formative years.

Experiences during these additional time periods could also include risky family environment and sexual abuse and also other experiences.

xiii. Obviously, this twin study of factors *common to* same-sex sexuality and depression does not include potentially causal experiences or rates of such experiences that may be *unique to an individual*. Negative social responses to sexuality may contribute, but more factors must be considered.

xiv. These findings of common factors in depression and same-sex sexuality do not support a view that greater prevalence of depression or suicidality is not inherent to same-sex sexuality, at least for some, and that greater prevalence of depression with same-sex sexuality is simply caused by societal discrimination.

e. The minority stress theory has harmfully restricted curiosity about other possible causes of suicidality and mental health problems in people who experience same-sex attraction. Michael Bailey, American psychologist, prominent sexuality researcher, and professor, a man who does not shy away from controversy, says the theory has not been proved. He published an article in 2020 with a title that raised this challenge: "The Minority Stress Model Deserves Reconsideration, Not Just Extension". In the article he said,

> Twenty years ago, I commented on two of the first careful epidemiological studies showing that nonheterosexual people were at increased risk of some mental health problems. I noted that although the idea that these problems arise from "societal oppression"—what has become known as "minority stress"—was certainly possible, other explanations were also possible and should be considered. I concluded that "it would be a shame—most of all for gay men and lesbians whose mental health is at stake—if sociopolitical concerns prevented researchers from conscientious consideration of any reasonable hypothesis (Bailey, 1999)."
>
> I am afraid that my fear has largely been realized. The minority stress model has been prematurely accepted as the default explanation for sexual orientation-associated differences in mental health. Yet minority stress research has not generated findings uniquely explicable by the model, and it has ignored the model's serious limitations. I understand discomfort about and hesitancy to study alternative models, such as the one proposed above [in Bailey's article]. But acceptance of an incorrect explanation helps no one.

f. The minority stress theory and the campaign to prohibit change-allowing therapy for same-sex sexuality or discordant gender identity has fostered for decades avoidance and neglect of research into other potential explanations of psychological distress and suicidality co-occurring with or underlying

same-sex sexuality or gender discordance that may need attention. Opposing therapy to explore and treat these does not appear to have decreased psychological distress or suicidality or to have improved mental health.

221. To prove scientifically that change-allowing therapy is generally "harmful," one would have to prove one or more of the following is true:

The number of clients who report *harm* from change-allowing therapy significantly exceeds those who report *benefits*.

Negative mental and physical health indicators among those who have undergone *change-allowing therapy* significantly exceed those among persons who have:

1. Undergone LGBT-identity *affirming* therapy.
2. Had no therapy at all.
3. Had therapy or counselling for other conditions.

There simply is no evidence that meets scientific standards to substantiate these points.

XV. GROWING EVIDENCE THAT RESEARCHERS WHO REPORT HARM AND RESEARCHERS WHO REPORT BENEFIT ARE STUDYING DIFFERENT SUB-GROUPS

222. There is growing evidence, coming largely from an ideologically diverse research team of LGB-identity-affirmative researchers and change-allowing therapy researchers working together, that researchers who report that change-allowing therapy for same-sex sexuality is helpful and researchers who report harm are studying different sub-populations of individuals who have same-sex experiences, with the conservative religious who reject an LGBQ label reporting helpfulness and the liberal or nonreligious who accept an LGBQ label reporting harmfulness. Broad generalisations have erroneously been made from research on only one subgroup. (Lefevor et al., 2019a; Lefevor et al, 2019b; Lefevor et al., 2020; Rosik et al, 2021a; Rosik et al, 2021b; Sullins & Rosik, 2024; Rosik et al., 2022) (Some of this research surveyed people who identify as LGBTQ, not only LGBQ, because many people who experience incongruent gender identity, "T", also experience same-sex sexuality, "LGB".) (Singh et al., 2021, de Vries et al., 2011; Kuper et al., 2020) ("Q" is for people who are questioning whether they experience LGB or T.) **For example, one of these studies (Rosik et al., 2021a) concluded the following.**

> **Rejection of an LGBTQ+ label appears to be a marker for a constellation of characteristics, such as conservative religious beliefs, greater religious participation, prioritization of a religious identity, and the primacy of living in chaste singleness or heterosexual relationship commitments** (Lefevor, Sorrell et al., 2020; Rosik, Lefevor, & Beckstead, 2021). **This may be why the rejection or adoption of an LGBTQ+ identity label was the most powerful**

predictor of perceived helpfulness of the goals of SOCE for our participants. (pp. 195-196, bold added)

The fact that rejection of an LGBTQ+ identity was the second strongest predictor and positively related to perceived helpfulness of the goals of SOCE underscores Lefevor et al.'s (2021) observation that **there is "a remarkable amount of heterogeneity" in the experiences of the sexual minority population.** (p. 196, bold added)

At least for these sexual minority participants, it appears **religious beliefs and identities are more influential in their perceptions of the helpfulness of change-oriented psychotherapy than direct interpersonal pressure or stigma or a lack of social support and connection.** (p. 196, bold added)

Thus, the underrepresentation of non-LGBTQ+-identified sexual minorities in research on SOCE generally and change-oriented psychotherapies in particular may plausibly *misrepresent* the experiences of those individuals who are traditionally religious. We hope establishing there is in fact a subgroup of people who report most goals of SOCE to be helpful will spur more research into identifying who these people are, rather than simply foreclosing clinical options for them. (p. 198, bold added)

223. **In a study of 33 self-help methods in the research literature for treating feelings of distress about one's same-sex sexuality, methods for helping to manage or decrease same-sex attraction and behaviours were rated as mildly to somewhat helpful for a *non-LGB-identified group* and mildly to somewhat harmful for an *LGB-identified group*. The intent of most of the methods is to help individuals who wish to live consistently with their conservative religious values. "Participants reporting a TC [theologically conservative] perspective often reported more helpfulness for these methods than TNC [theologically non conservative] participants, who in turn reported less harmfulness than NT [non theological] participants."** (Rosik et al., 2022, abstract, bold added) Methods that all identity groups and all theological groups found helpful were those that are neutral toward same-sex sexuality in the sense that they do not encourage, discourage, or necessarily directly address a sexuality but are helpful to people in general. Examples are "working through sexual trauma, learning to be assertive, and learning how to develop deeper connections with others". All groups rated aversive cognitive and behavioural techniques as somewhat to moderately harmful. (Rosik et al., 2022) An ideologically diverse research group conducted this survey of 281 identity and theologically diverse adults who reported having experienced or currently experiencing distress about their same-sex sexuality. Studies by this research team have found that non-LGB-identified people experience methods that help them reduce same-sex fantasising or behaviour as helpful. (Rosik et al., 2021a; Rosik et al., 2022)

224. **Research does not support the view that traditional religions cause mental health disparities or suicidality for people of traditional religions who experience**

same-sex sexuality or the view that those of traditional religion would have better mental health if they converted to liberal or no religion.

a. **A study of meta-analyses that include 73 studies found a positive relationship between spirituality or religious belief with health, but this relationship disappears or becomes negative when research participants are solicited from LGB specific venues such as LGB bars or clubs, as occurs in 75% of studies regarding religion or spirituality and the health of individuals who have same-sex sexuality or incongruent gender identity experiences.** (Lefevor et al., 2021, abstract; Rosik, 2021a) LGBT-identified research participants tend to be largely disaffiliated with conservative religions (Dehlin et al., 2015; Bradshaw et al., 2015; Sullins & Rosik, 2024), hence studies of LGBT-identified people cannot be assumed to be representative of people who experience same-sex attraction or gender incongruence and are traditionally religious.

b. **The originator of the minority stress theory and a co-author found attendance at an LGB-identity-non-affirming church was associated with higher "internalized homophobia" but was unrelated to global self-esteem. (Barnes & Meyer, 2012, p. 509) Also, "There was no main effect of nonaffirming religion on mental health," contrary to the researchers' expectations.** (Abstract) This was a nonrepresentative study of "355 LGBs" in New York City.

    i. LGB-identity affirming researchers have frequently measured negative beliefs about homosexuality as "homonegativity" or "internalized homophobia" and presumptively interpreted this in non-LGB-identified people as beliefs about self.

    ii. **Negative views of homosexuality among traditionally-religious, same-sex-attracted people likely represent movement toward religious beliefs, not beliefs about self, self-hatred, or shame. Whereas LGB-identified people generally view same-sex attraction feelings as who they are (their identity), hence perceive views about homosexuality as views about self, non-LGB-identified people perceive same-sex attraction feelings as feelings they *have*, not who they *are*. Thus, views about homosexuality are not necessarily views about self.** (Rosik et al., 2021a; Hallman et al., 2018)

c. **Those who follow their traditional faiths that reject same-sex relationships are no less happy, mentally healthy, satisfied with life, resilient, and flourishing than those of faiths that accept same-sex relationships or those of no faith** according to findings in the following studies.

    i. **Nationally representative research in the U.S. concluded that LGBT-identified individuals who identified as agnostic, atheist, or having no religious affiliation reported lower levels of happiness compared**

to mainline Protestants. "Surprisingly, no significant differences are found between mainline Protestants (whose church doctrine often accepts same-sex relations) and evangelical Protestants (whose church doctrine often condemns same-sex relations)." The study failed to distinguish and compare traditional versus liberal adherents within the Catholic faith or within other religions as they did with Protestants. (Barringer, 2020; Barringer & Gay, 2017, abstract)

ii. **This finding on flourishing has been confirmed in a growing number of studies by the ideologically diverse team of LGB-identity-affirming researchers and change-affirming researchers working together that was mentioned above.** (Lefevor, Davis, et al., 2021; Lefevor, Sorrell, et al., 2019; Rosik et al., 2021).

iii. **The Faith and Sexuality Survey report in the U.K. (Ozanne, 2018) also confirmed** SSA- (same-sex-attraction-) identified participants who are likely more religiously traditional were also the most spiritually satisfied.

iv. **Traditionally-religious same-sex attracted people in Nigeria were less suicidal (Ogunbajo et al., 2022), and religious Black American same-sex attracted people of conservative beliefs (assessed as "homonegativity") were more resilient (Walker & Longmire-Avital, 2013) than progressive religious people, yet researchers in these studies remarkably and in direct contradiction to their findings, concluded that the traditionally religious would benefit from becoming religiously progressive. These studies do not show that conservative-religious, same-sex attracted people benefit from liberal beliefs.**

d. **Research conducted by LGBT-identity-affirmative researchers found religious schools ranked among the safest schools for LGBTQ+ identified students in the United States.** This is according to my review of the data in the GLSEN 2017 School Environment Survey published by GLSEN, formerly called the "Gay, Lesbian, Straight Education Network". (Kosciw et al., 2017, Appendix 2) Coercing use of LGBTQ+ identity-affirmative methods recommended by GLSEN in schools, however, may reduce safety for traditionally religious students. (Haynes, 2019)

i. It appears that non-LGBT-identified students were omitted from the survey given the low representation of religious students. Participants were 23,001 LGBTQ+ identified youths and were solicited from LGBTQ+ identity advocacy organisations or social media sites in all 50 U.S. states. The GLSEN research website revealed to participants that the researchers were LGBT-identity-affirmative only. Participants were mostly gay- and lesbian-identified (42%) rather than bisexual identified (27.8%), and were white (67%), non-religious, atheist, or not

affiliated with any religions listed (59%), and female (77%). (Table M1 on p. 8)

ii. Given that participants were told the survey was being conducted by GLSEN, that is, by LGBT-identity-affirming only researchers, and that the survey solicited LGBT-identified participants who were mostly not religious, there was a high risk for participants to confirm viewpoints of the researchers that were contrary to traditional religious viewpoints. One might expect the participants' views of religious schools would be, if anything, negative.

iii. Further, the GLSEN survey found that religious schools did not have LGBTQ+ affirming curricula, clubs, website access, library resources, textbooks, teachers, administrators, or policies. From these findings, one might expect religious schools would be the most dangerous environment for sexual or gender minority students.

iv. The survey actually found, however, that religious schools ranked among the safest for LGBTQ students, with fewer anti-LGBTQ remarks among students than in public schools, and the least victimisation and bullying of any schools. In fact, their rates of bullying were lower than those of the private non-religious schools that used all the suggested LGBTQ-affirmative educational methods (Appendix 2).

e. **The large Healthy Minds survey conducted in 140 U.S. universities (135,344 participants) from 2020 to 2021 found, overall, there were no differences in anxiety or suicidal ideation for LGBT-identified students across Catholic, evangelical, "Other Christian" (Episcopalian, Lutheran, Presbyterian, Baptist), and nonreligious universities. In fact, importance of religion was generally associated with lower suicidal ideation and anxiety across universities.** "Universities request to be part of the Healthy Minds study and are provided detailed feedback on their student body (all data are anonymized). At larger universities, a random sample of 4,000 students were invited to participate via email. At smaller universities, all students were invited." (Dyer & Erickson, 2023, p. 184)

i. Students for whom religion was unimportant had greater anxiety at nonreligious than Catholic universities. One might have expected, based on minority stress theory, that these students would experience more affirmation and therefore less anxiety at nonreligious universities, but the opposite was the case. The researchers suggested it is possible that a religious community helped to decrease risky behaviour.

ii. **There was also evidence that there are different sub-populations of students who experience same-sex attraction or gender discordance, such that students who practice evangelical religious faith**

experience evangelical religious communities as supportive, while students who do not practice evangelical faith may feel they do not fit with the evangelical community or experience it as supportive. This large study provides more evidence that research findings made based on LGBT-identified young people who do not practice traditional religious faith do not generalise to young people of sexuality or gender diverse experiences who do practice traditional religious faith. At evangelical universities, LGBT-identified students who *did not participate* in extracurricular religious activities had more suicidal ideation than LGBT-identified students at nonreligious universities, but LGBT-identified students at evangelical universities who *did participate* in extracurricular religious activities had low suicidal ideation.

225. The key to mental health may be social connectedness and belongingness, not progressive religious beliefs about same-sex sexuality. Members of the MoU should be fostering social connectedness, not censoring traditional religious beliefs and therapy that is consistent with them.

a. The survey just mentioned above of men who have had sex with men in the very religious country of Nigeria that is mostly Christian and Moslem "found that individuals who believed sex between two men was a sin were less likely to report history of suicidal thoughts and attempts" and "reported higher levels of perceived social support" (such as belongingness or community connectedness), which, in turn, was significantly associated with frequency of religious attendance. (Ogunbajo et al, 2022)

b. In the U.S., an ideologically diverse research team surveyed both non-LGB-identified (or same-sex attraction identified/SSA identified) and LGB-identified adults, nearly all of whom were raised with a religious affiliation and the large majority of whom currently were in a religious affiliation. Participants' satisfaction was compared among 4 relationship groups—single and sexually abstinent, single and not abstinent, in an opposite-sex relationship, and in a same-sex relationship. These groups likely reflect different beliefs about same-sex behaviour. The researchers found that "meeting needs for connection, intimacy, and mutual understanding was the strongest predictor of satisfaction across all options." (Lefevor, Beckstead, et al., 2019)

c. **Non-LGB-identified people may not experience belongingness in an LGBT-identity community, because they do not value an LGBT-identity lifestyle and culture and do not find it fulfilling.** (Byrd, Nicolosi, & Potts, 2008) **Belongingness and community connectedness for people who experience same-sex attraction (or gender discordant identity) come in many forms and are not unique to liberal religious or non-religious LGB-identity communities that are not a fit for everyone. Supportive communities that hold viewpoints that are not MoU approved can enhance mental health and reduce suicidality**.

226. The erroneous generalising of research on LGB identified people to non-LGB-identified people has resulted in well-meaning, LGB-identity-affirmative researchers and clinicians recommending therapist-initiated, LGB-identity-affirmative therapy on non-LGB-identified clients who do not want this, do not consent to it, and do not feel it is affirmative of them. This is affirmative conversion therapy. It may be experienced as non-affirming, unhelpful, and coercive. Specifically, some researchers and clinicians have recommended treating traditionally religious, non-LGB-identified clients by trying to get them to convert to be LGB-identified and to convert their religion to liberal religion when the clients were not requesting help to so. Some professionals have even acknowledged such activity is unethical but promoted it anyway. These same professionals may routinely call for respect and non-discrimination regarding sexuality and religion. (Przeworski et al., 2021; Weir, 2017) Some professional therapy clients have reported they experienced as unhelpful therapists who "attempted to impose gay affirmative therapy on them" when doing so was not the client's desire or goal. (Nicolosi, Byrd, & Potts, 2000, p. 1082; Throckmorton & Welton, 2005; British Board of Scholars and Imams et al. (SCIO), March 2024)

a. **Structured interviews with participants who desired therapy to change their sexuality found the participants preferred therapists who valued their goals, values, and beliefs.** Specifically, participants (Throckmorton & Welton, 2005, p. 16)

> preferred therapists who indicated that they believed that a gay or lesbian identity is negative, who did not support maintenance of lesbian and gay relationships, who was quite knowledgeable about the lesbian and gay communities, who never made an issue of sexual orientation when it was not relevant, who helped clients look for and understand causes of same-sex attraction, who indicated that having same-sex attractions did not necessarily signal a necessity to identify as gay or lesbian, who suggested strategies to minimize same-sex attractions, who suggested strategies to enhance heterosexual attractions, who helped clients feel good about themselves as an ex-gay or ex-lesbian, and who suggested that you should develop non-sexual friendships with same-sex peers.

b. **The British Board of Scholars and Imams, Muslim Council of Scotland, and Muslim Council of Whales have published a joint statement on "Conversion Therapy" giving testimonies of the harms that have resulted from professional therapists in the U.K. trying to practice affirmative therapy on Muslims who want to live by their faith. The risks include extreme and long lasting psychological distress. Muslims benefitted from support from the love of God and support groups for people who shared their values and beliefs.** (British Board of Scholars and Imams et al. (SCIO), March 2024)

227. **The professional organisations in the U.K. should require clinicians to have training in research and therapy for the population of non-LGB-identified people, at least sufficiently to make referrals competently (Nicolosi, Byrd, & Potts, 2000), and they should recommend that clinicians who do not have expertise in treating this population should refer to those who do. The MoU unethically and harmfully obstructs much-needed training for clinicians in this research literature and prohibits such research-informed clinical practice.** Some LGB-identity-affirmative researchers have criticised clinicians who treat non-LGB-identified clients according to expertise for this specific client subgroup as lacking in skills, because they do not apply LGB-identity-affirmative therapy to all same-sex attracted clients. (McGeorge et al., 2013)

228. **Growing research has demonstrated there are different sub-populations of people who experience same-sex attraction, and research is needed to look into the corollary for people who experience gender discordance. There is no research evidence that imposing LGBT-identity-affirmative therapy is safe or effective for non-LGBT-identified people who do not want it or consent to it. There is research evidence that change-allowing therapy for non-LGB-identifying people improves their mental health and reduces suicidality. Might the same be true for gender discordant people who desire change in the direction of becoming contented with their innate body?**

229. **The MoU violates its own ethical standard against changing a person's sexual "orientation" or gender identity or suppressing their expression and is self-prohibiting. For same-sex sexuality, the MoU favours an LGBT-identity as inherently preferable to traditional-religious-identity/non-LGBT-identity and supresses support for behavioural expression of the latter which is abstinence or heterosexual behaviour.** "For people who are unhappy about their sexual orientation or their gender identity," it supports therapy to help them "reach a greater degree of self-acceptance." This appears to mean helping them change to a viewpoint that their same-sex or discordant gender identity feelings or behaviours are *who they are*, hence attempting to change their "orientation", to speak in MoU terms, from religious-identity/non-LGBT-identity to LGBT-identity. For discordant gender identity, the MoU prioritises body conversion therapy (so to speak) over exploratory subjective feelings "conversion therapy". (MoU, July 2024)

a. **Therefore, the MoU signatories meet their own definition of conversion therapy:**

> **"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."** (MoU, July 2024)

b. **Ironically, the signatories of the MoU do not follow their own "ethical practice" standard that requires a practitioner to have adequate diversity knowledge and to be free from a biased agenda.** The MoU LGBT-identity-centric guidance demonstrates diversity ignorance that non-LGBT-identified people do not share the viewpoint that the "self" is a person's sexual "orientation" or gender identity that is discordant to their innate sex and biological reproductive role. Nor do they want affirmative conversion therapy to change them to that viewpoint. A "practice" to "help" them accept discordant gender "identity" as supposed "self-acceptance" is not a therapy goal that is initiated by these clients. They do not experience it as accepting or affirmative of the authentic self. It is a therapist- or MoU-imposed therapy goal to change a person's "orientation" or identity against the person's own will, based on a biased agenda that promotes a sexual orientation or gender identity the MoU prefers. It is coercive affirmative conversion therapy. **The MoU states,**

> **"Ethical practice in these cases requires the practitioner to have adequate knowledge and understanding of gender and sexual diversity and to be free from any agenda that favours one gender identity or sexual orientation as preferable over other gender and sexual diversities."** (MoU, July 2024)

c. **The MoU is self-prohibiting. The MoU condemns its own practice as unethical.**

XVI. PROFESSIONAL ORGANISATION SUPPORT FOR CHANGE-ALLOWING THERAPY; THERE IS NOT A PROFESSIONAL CONSENSUS IN OPPOSITION

230. A number of medical, mental health, and social science organisations accept change-allowing therapy for distress over undesired or unfulfilling same-sex feelings or behaviours or gender incongruence. They accept a client's counselling choice for therapy that explores their potential to manage, reduce, or change same-sex attraction or behaviour or discordant gender identity or expression. Here are some of these organisations: (Haynes, 2024d, periodically updated, gives links for each organization)

International Foundation for Therapeutic and Counselling Choice (serves over 30 nations)
https://iftcc.org/the-declaration/

International Federation of Catholic Medical Associations (has about 80 member organisations around the world)
https://www.fiamc.org/bioethics/homosexuality-hope-homosexualidad-y-esperanza/

American Association of Christian Counselors (conducts large international conferences every-other year)

https://aacc.net/wp-content/uploads/2023/02/AACC-Y-2023-Code-of-Ethics-FINAL-Draft.pdf

Christian Medical Fellowship (UK)
https://admin.cmf.org.uk/pdf/publicpolicy/CMF_response_to_Conversion_Therapy_Ban-FINAL.pdf

Alliance for Therapeutic Choice and Scientific Integrity (USA)
https://docs.wixstatic.com/ugd/ec16e9_1d6108cfa05d4a73921e0d0292c0bc91.pdf

American College of Pediatricians
https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth
https://biologicalintegrity.org

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

Christian Medical and Dental Associations (USA)
https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf

Catholic Medical Association (USA)
https://acpeds.org/assets/imported/5.25.17-Joint-Therapy-letter-with-signatures.pdf https://www.cathmed.org/resources/cma-protests-california-bill/

Society of Catholic Social Scientists (USA)
https://catholicsocialscientists.org/wp-content/uploads/2023/07/soce_resolution_103021.pdf

231. **An increasing number of medical and mental health professionals and organisations internationally are issuing warnings about "gender affirmative" medical interventions and, among these, many are moving toward prioritising psychotherapy, in contradiction to the MoU that accepts gender-affirmative interventions and opposes prioritising psychotherapy to resolve gender dysphoria, at least if there is a disapproved viewpoint.** Here are some of the organisations raising concerns or even dissenting from the gender-affirmative approach that the MoU takes:

Academy of Royal Medical Colleges (23 member medical organisations and faculties from the U.K. and Ireland)
https://www.aomrc.org.uk/publication/academy-statement-implementation-of-the-cass-review/

Royal College of General Practitioners (U.K.) (June 2019, Transgender care at Paragraph 15.) https://www.rcgp.org.uk/representing-you/policy-areas/transgender-care

Swedish Paediatric Society:
http://www.barnlakarforeningen.se/2019/05/02/blf-staller-sig-bakom-smers-skrivelse-angaende-konsdysfori/

Alliance for Therapeutic Choice and Scientific Integrity (U.S.):
https://www.therapeuticchoice.com/transgender

American College of Pediatricians (U.S.):
https://biologicalintegrity.org

Association of American Physicians and Surgeons (U.S.):
https://aapsonline.org/aaps-statement-on-gender-affirming-care-for-minor-children/

Catholic Medical Association (U.S.):
https://www.cathmed.org/?s=transgender#

Christian Medical and Dental Associations (U.S.):
https://cmda.org/policy-issues-home/position-statements/

European Society of Child and Adolescent Psychiatry:
(Radobuljac et al., 2024)
https://doi.org/10.1007/s00787-024-02440-8

Gender Exploratory Therapy Association:
https://www.genderexploratory.com

128th German Medical Assembly (250 delegates from 17 medical associations):
https://segm.org/German-resolution-restricts-youth-gender-transitions-2024?inf_contact_key=dd71900c33a0e6838d687473d0bbc509d18a532c4142cb79caf2b269de1401fa

Indiana State Medical Association (U.S.):
https://donoharmmedicine.org/2023/09/13/progress-at-indianas-main-medical-association/

Italian Psychoanalytic Society:
https://feministpost.it/en/primo-piano/gli-psicanalisti-italiani-stop-ai-puberty-blockers/

National Academy of Medicine (France):
https://segm.org/sites/default/files/English%20Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf

National Association of Practicing Psychiatrists (Australia):
https://napp.org.au/webinar-registration/

Royal Australian and New Zealand College of Psychiatrists (RANZCP):
https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria

Society for Evidence Based Gender Medicine (international):
https://www.segm.org

The American Society of Plastic Surgeons has reportedly told Fox News that it "has not endorsed any organization's practice recommendations for the treatment of adolescents with gender dysphoria," and "ASPS is reviewing and prioritizing several initiatives that best support evidence-based gender surgical care to provide guidance to plastic surgeons". (Tietz, 15 August 2024) https://www.foxnews.com/media/american-society-plastic-surgeons-breaks-consensus-medical-establishment-transgender-care.

The Royal College of Psychiatrists (U.K.) said that, since the Cass interim report was published, it plans to review its guideline for treatment of gender dysphoria.
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_18.pdf?sfvrsn=af4d4aad_21.
It has published a generally favourable response to the Cass Report.
www.rcpsych.ac.uk/news-and-features/latest-news/detail/2024/04/22/detailed-response-to-the-cass-review's-final-report

232. There is not a professional consensus in support of the MoU's affirmative-only position on discordant gender identity, sexuality, and therapy. Organisation statements about change-allowing therapy to treat distress about unfulfilling or undesired sexuality or gender identity are opinions of guilds that may be expressing a worldview, not scientific statements. The MoU is an example.

CLOSING

XVIII. COMMENTS ON THE MEMORANDUM OF UNDERSTANDING

233. The MoU indicates it supports "appropriate" research. I suggest, however, that the aforementioned research may never have been properly considered by the authors or signatories.

234. The MoU is viewpoint discrimination. It violates a client's most profound and fundamental freedoms and rights to self-determination in many domains, hence is

unethical and unjust. In light of existing research, the MoU does not have a case of incontrovertible scientific justification for taking away these freedoms and rights. Based on a viewpoint, the MoU remarkably polices thoughts, speech, values, ethics, conscience, beliefs, sexual feelings, sexual behaviours, gender identity, gender expression, procreative relationships, marriages, families, many religions, and many cultures.

235. The MoU lacks clarity as to whether it ever permits change-allowing therapy, perhaps if there is not an unapproved viewpoint. Some people experience distress from their same-sex sexuality or discordant gender identity. The methodologically best available research has found that therapy that is open to their desire to manage, decrease, or change these has for many decreased their distress, strongly and clinically improved their psychological well-being, reduced their risk of HIV transmission, treated them for behaviours that resulted from trauma or that met diagnostic criteria for a standard psychiatric diagnosis, protected their marriage and family they love, enabled them to begin a procreative marriage and a family or to be comfortably abstinent, protected their observance of the religion of their heart, or enabled them to walk away from sexual or gender experiences they found unfulfilling. Some detransitioners want therapeutic assistance to resolve gender dysphoria that medical interventions did not help, and some gender dysphoric people prefer or medically require non-medical interventions and similarly want this help. It would be absurd, harmful, and unjust to forbid this therapeutic support for each-and-every one of these reasons. **If the MoU does allow such support in some cases, it should allow anyone such support for whatever reason they wish without viewpoint discrimination.**

236. The reality that the signatories of the MoU continue to promote the gender-affirmative-only approach for all ages in the face of the comprehensive four-year Cass Review is evidence as to how far unscientific affirmative gender ideology has captured the professional organisations. It demonstrates that professional eminence is not scientific evidence.

237. The United Kingdom has several years of experience with a "conversion therapy" ban because of the MoU, and the result has been a marked reduction of access to care for gender dysphoric young people as well as for unacknowledged non-LGBT-identified people. This has been a disaster. As NHS-England and potentially the U.K. are making a fundamental change away from an affirmative-only approach to psychosocial treatment for gender dysphoria, the MoU is simultaneously still being permitted, without scientific justification, to enforce an affirmative-only approach on therapists. The need for resolution is urgent.

238. The social stigma and marginalizing, if not social erasing, of non-LGBT-identified people has left them in a precarious and protracted situation of not getting care. Many of them are trying to save their marriage and family and some are suicidal. Under the MoU, while LGBT-identified people receive therapy, non-LGBT-identified people are reporting they cannot get help from accredited therapists. This

critical situation is dangerous and unjust. **Professionals are left generally untrained in understanding and caring for this population.**

239. **Studies published largely since the Coventry Review reveal a population of sexuality diverse people for whom change-allowing therapy, and not an LGB-affirmative approach, is culturally sensitive and appropriate, safe, and effective.** Recent research has found client-centred therapy that some clients prefer to decrease distress about their sexuality experiences and that may or may not result in reduction or some degree of change in their same-sex behaviour or attractions is safe, improves mental health, is at least partially effective for them in many cases, and reduces suicidality. Research that has claimed harm has now been shown to have made significant errors, to have largely or entirely excluded this non-LGB-identified subpopulation, and to have drawn invalid generalisations. Prohibiting care that is affirming, safe, and effective for non-LGB-identified people and consistent with their preferences, values, beliefs, and life goals is not scientifically justified, and coercing LGB-affirming treatment on them is culturally inappropriate, unethical and harmful to the point that it can be dangerous.

240. **A viewpoint that same-sex attracted or gender-discordant individuals could not possibly freely choose professional help to align their sexuality or gender self-perception with their personal fulfilment, mental health needs, religion, and/or desired or actual opposite-sex marriage and their family apart from "externalised and internalised oppression" is itself prejudiced and oppressive.** (UKCP, no date, p. 4) Exercising these preferences is a human right. The assumption of coerced external motivation denies that these individuals can have agency that is motivated by self-knowledge, love of their spouse and children, and love of the beauty of their religion that brings them happiness. There is nothing inherently wrong with a preference for exploring one's capacity for a procreative relationship. Having this preference should not be prohibited or stigmatised on an assumption that it could only be the result of stigma or is stigmatising.

241. **The reality that some clients do not find an LGBT identity fulfilling and desire change allowing therapy may be an offensive or painful reality to some others. An ethical approach** is not to stigmatise or forbid them. Surely a compassionate approach can allow those who want therapy to explore their sexuality or gender identity to have the freedom to do so. This is the ethical stand to take, and taking away this freedom is unjust.

242. **Viewpoint gatekeeping restricts *clinical* curiosity and inquiry** by mental health and medical practitioners and, not the least, the clients themselves. This is an injustice to care givers, patients, and to society, and it is harmful. I personally benefitted from being a member of a professional peer tutorial group for 14 years in which professional members confidentially discussed anonymised cases that included LGBT-identity-affirming care and change-allowing care. This professionally enriching experience was possible because members did not require each other to agree, and members were interested in varying viewpoints.

243. **Subjecting *research* evidence to the reduced scrutiny of one viewpoint in the MoU, that cannot under any circumstances be challenged, has resulted in loss of rational debate, scientific evidence**, criticality, freedom of thought, academic freedom, and freedom to research. Such unfortunate loss of diversity of viewpoint is a major obstacle to progress in research and treatments. It is important that there be openness to new evidence in ongoing scientific and academic debate. For this to exist, freedoms for individuals to hold beliefs and viewpoints are required.

244. **The inherent right for desiring people to have help to live out their sexuality and gender as they see fit is prohibited in the MoU. The MoU signatories, in effect, gate-keep non-LGBT-identified people from exiting MoU-mandated sexuality and gender identity.**

245. **As I have stated, I believe we can all agree in denouncing abuse. If it occurs in the U.K., it is already rightly illegal. We should also agree that *all* people who experience same-sex sexuality or discordant gender identity should have the same right to support as everyone else to protect their health, to treat a recognized psychiatric disorder such as compulsive sexual behaviour, to protect their marriage and family, and to live consistently with their religion that gives them joy and should be respected.** Randomized controlled studies, longitudinal studies, and additional research show they may achieve these therapy and life goals through therapy that decreases their distress, improves their well-being, may reduce same-sex behaviour as needed, and may or may not change their sexual attraction feelings. **Yet, under the MoU, therapists are afraid to provide them support that may lead to these outcomes.**

246. **In light of these concerns, research and professional ethics require that professionals and clients have these rights:**

a. **Mental health professionals should have a right to religious viewpoint freedom on sexuality, gender identity, and therapy that is culturally sensitive and appropriate for traditionally religious clients and a right to offer professional practice consistent with this viewpoint to desiring patients, and professional organisations should not take away these rights.**

b. **Clients should have the right to choose an *accredited* professional to care for them who shares their worldview and is able to help them from within it and should no longer be deprived of this.** MoU signatory organisations are denying this right based on viewpoint discrimination that acts against religious and cultural values and goals for marriage and family. Many clients desire a professional therapist who can treat them from within their religious worldview and have said they have felt having such a therapist was extremely beneficial for them.

c. **Viewpoint freedom requires that professionals, who share the traditional religious worldview of some clients on sexuality and gender and who are**

open to their therapy goals be allowed professional training and membership in professional organisations.

d. **Professional ethics should require that professionals receive training in similarities and differences among conservative religious, liberal religious, or non-religious people who experience same-sex or gender-discordant feelings or behaviours.** LGBT-affirmative approaches are not experienced as a fit for all and may marginalise, stigmatise, pathologise, and harm people who have same-sex attraction feelings or incongruent gender identity feelings and who do not experience these feelings they have as defining who they are.

247. **The difficulty with therapy bans was succinctly expressed** in the court complaint of Dr. David Schwartz, a psychotherapist who successfully supported the right of his clients to change-allowing therapy for same-sex attraction in New York City. As a result of Dr. Schwartz's case, the city council voted to repeal its own therapy ban.[11] His complaint said therapy censorship allows therapists "to assist individuals in directing and redirecting their sexual desires and relationships in any imaginable direction except towards congruence with the natural reproductive function—that is, towards stable heterosexual attraction" aligned with objective sex and its biological reproductive nature.[12] "Indeed, the ability to reproduce—to be a father or mother to children, as the case may be, and to participate in the small society that consists of two parents and their children—has been widely held across culture and across history to be one of the greatest sources of joy in life."[13] Professional organisations should not prohibit clients, who desire this kind of life or "who have already entered into a heterosexual marriage, given life-long promises, and begotten or borne children" [14] from having support to live this way more successfully, easily, and enjoyably.

XVIII. CONCLUSION

248. The MoU prohibits much warranted therapy for those who desire it and wrongly prohibits therapists and counsellors who are willing to offer such professional care. These prohibitions violate fundamental client rights without the necessary incontrovertible scientific evidence to justify doing so. Lack of clarity in the MoU may have seriously harmful unintended consequences. The MoU prohibitions are harmful and unethical.

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XX. 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 I 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 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 might 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 identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;

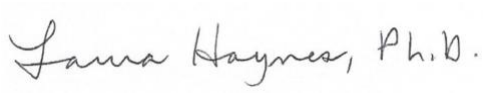
    d. The court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;

    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.



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Laura Haynes, Ph.D.

9 January 2025
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Date

XXI. CURRICULUM VITAE:

Laura Haynes, Ph.D., Psychologist
P. O. Box 653, Tustin, CA 92781, U.S.A.
laura.haynesphd@iftcc.org
9 January 2025

Laura Haynes, Ph.D. is a psychologist retired from clinical practice after 40 years of experience. She now reviews research, writes, and speaks on sexuality and gender internationally. Her mission is advocating for the freedoms and rights of individuals who feel distress from their sexuality or gender identity to receive professional and pastoral counseling to decrease distress, improve psychological well-being, and manage, reduce, or change undesired same-sex attraction or behavior or undesired gender-sex discordant identity or expression, and to live according to the preferences, beliefs, and values that bring them true happiness. Dr. Haynes has served as an expert internationally for professional organizations, members of parliaments and legislatures, courts, United Nations delegates, and high-level government officials. People in over 80 nations and in 20 languages have heard, read, or received research reviews from Dr. Haynes.

EDUCATION:

BIOLA UNIVERSITY, Rosemead Graduate School of Psychology
La Mirada, California (free standing school in Rosemead when I graduated).
Ph.D., Counseling Psychology (Clinical emphasis), May 1977
M.A., Counseling Psychology (Clinical emphasis), June 1974

SOUTHERN METHODIST UNIVERSITY
Dallas, Texas
M.A., Experimental-General Psychology, May 1972

WESTMONT COLLEGE
Santa Barbara, California
B.A., Sociology (with equivalent of a minor in New Testament Greek), June 1970

FULLER THEOLOGICAL SEMINARY

Pasadena, California
M.A., Theology, June 1979

CERTIFICATIONS:

1978 to present: California Licensed Psychologist (PSY5850).

2016 EMDR Trained.

POST LICENSE TRAINING (past 10 years):

2023 Reintegrative Therapy, audited basic course. Luke Dougherty, LMFT, Certified Reintegrative Therapist, instructor.

2016-2018 EMDR peer-consultation group led by Curt Rouanzoin, Ph.D., Approved EMDR Consultant, Instructor. Served as a Senior Facilitator and Specialty Presenter for the EMDR Institute until 2017.

2003-2017 Psychoanalysis reading group and case tutorial group with Lawrence E. Hedges, Ph.D., Psy.D, ABPP, ABFE, California Board of Psychology Expert Witness, founding training and supervising psychoanalyst, Newport Psychoanalytic Institute (NPI).

PROFESSIONAL ORGANIZATIONS:

2020-present Sexual and Gender Identity Task Force Member, Christian Medical and Dental Associations (CMDA).

2018-present International Foundation (previously Federation) for Therapeutic and Counselling Choice: Executive Board Member (as of 2023, previously General Board Member), Country Representative for the U.S.A., Chair (since 2023, previously Member) of Science and Research Council. IFTCC Award, October 19, 2024, to Chairman, IFTCC Science and Research Council: “In Recognition of her Scholarship Excellence in Service to the IFTCC, Internationally”. Poland.

1993-present Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) (formerly National Association for Research and Therapy of Homosexuality): Member 1993 to present, Member Research Committee 2017 to present.

1992-1995 Christian Association for Psychological Studies—Western Region (CAPS-West, covering the western United States and western Canada):

	President Elect, 1992-1993, President 1993-1994, Past President 1994-1995.
1979-present	American Psychological Association, Member since 1979 (APA), Lifetime Member.

RELEVANT WORK EXPERIENCE:

2019	ALLIANCE DEFENDING FREEDOM Research consultant for expert declarations and cross examination questions.
2018-present	Speaking and writing about research on sexuality and gender as they relate to the right to change-exploring therapy in law.
1978-2018	Private practice, variously in Hacienda Heights and Tustin, California, U.S.A. Areas of Practice: Depression, Anxiety, Homosexuality, Marriage, Psychological Evaluations, Faith-Based Concerns.

PRESENTATIONS: (Past 10 years)

Confidential	Addressed or gave interviews to United Nations diplomats, high-level government officials, and members of parliaments.
2016-present	Various oral and written testimonies presented to legislative hearing committees of U.S. states on proposed legislation.
2024-10-20	Introducing the Science and Research Council. Presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.
2024-10-19	Gender Dysphoria Treatment: The Cass Review and Other Research Updates. Presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.
2024-4-27	Protecting the Legal Right to Therapy: Support from Research on Sexuality and Gender Published in English. Webinar for the International Christian Medical and Dental Association—Latin America.
2024-4-24	Protecting the Legal Right to Professional and Pastoral Counselling Support from Research on Sexuality and Gender. IFTCC Parliamentary briefing, London.

2024-3-19, 20 LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This—Latest Update. Tepeyac Leadership Institute. Online presentation for Western students; repeated for international students.

2023-11-4 Protecting the Right of Children in Barbados to Sing That Jesus Changes Lives. Family-Faith-Freedom, Barbados. Online conference.

2023-10-20 Research and Leading Clinicians on Gender Dysphoria Psychotherapy. Invited plenary presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.

2023-3-21, 22 LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This--Updated. Tepeyac Leadership Institute. Online presentation for Western students; repeated for international students.

2022-12-7 Transing Kids Is a Bad Idea—3 Reasons Why. Parliament of the European Union, Brussels, Belgium. Educational meeting for parliamentarians and staffers sponsored by Christine Anderson, Member of the European Parliament representing Germany (political party AfD—Alternative for Germany).

2022-10-29 Transing Kids Is a Bad Idea—3 Reasons Why. Marriage, Sex, and Culture (MSC) Conference, Transing Kids: A Good Idea? Part 10. (MSC is based in the United Kingdom.) Zoom event with Christine Anderson, Member of the European Parliament representing Germany (political party AfD—Alternative for Germany).

2022-10-17 Pathways to Heterosexuality and Homosexuality; Psychoanalytic Theories Made Easy. Plenary presentation. Conference of the International Federation for Therapeutic and Counselling Choice. Hungary.

2022-9-27, 28 LGBT Ideology and Activism Are Causing Serious Harms: Let's Change This. Belize City, Belize. Presented at the invitation of the Diocese of the Catholic Church that serves Belize City and the national capitol city, Belmopan. Separate presentations to priests, lay leaders in Diocese churches, superintendents responsible for the education of 70% of secondary school students in the nation of Belize, and an ecumenical group of Protestant pastors.

2022-8-6 Research on Gender Incongruence: Causes, Change, and Treatment. Online presentation, Conference: Critical Conversations on Gender and Identity. Hendricks Center, Dallas Theological Seminary. Dallas, Texas.

2022-8-6 Research Help for Sexuality Questions the Church Faces Today: Causes, Change Through Life Experience, Therapy, and Faith-Based Care. Online presentation, Conference: Critical Conversations on Gender and Identity. Hendricks Center, Dallas Theological Seminary. Dallas, Texas. Zoom.

2022-4-18	Health and Human Services Section 1557 Proposed Amendment—Opposed. Testimony on behalf of the IFTCC to the Office of Information and Regulatory Affairs (OIRA) of the White House Office of Management and Business (OMB).
2022-3-22	LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This. Tepeyac Leadership Institute. Online presentation for Western students.
2021	Expert interview in documentary: D. James Kennedy Ministries, The Tragedy of Gender Confusion.
2021-Nov. 6	Protecting the Right to Therapy: Same Sex Attraction and Incongruent Gender Identity: Research on Causes and Change Through Life Experience, Therapy, and Faith-Based Care. Webinar presentation, co-sponsored by Dallas Theological Seminary and the Christian Medical and Dental Associations.
2021-Oct. 18	Research on Gender Incongruent Identity: Causes, Change, Treatment, & Bans. Plenary presentation, conference of the International Federation for Therapeutic and Counselling Choice, Hungary. Simultaneous translations.
2021-Oct. 17&18	Pathways to Heterosexuality and Homosexuality: Psychoanalytic Theories Made Easy. Workshop presented on both dates, conference of the International Federation for Therapeutic and Counselling Choice, Hungary. Simultaneous translation.
2021-Sept. 22	Haynes, L. & Davidson, M. IFTCC Oral Submission to members of the Judicial Committee of the New Zealand Parliament on the "Conversion Practices Prohibition Legislation Bill". https://www.facebook.com/JUSCNZ/videos/2962519317294188/?extid=NS-UNK-UNK-UNK-IOS_GK0T-GK1C
2021-Sept. 2	Conversion Therapy: Should It Be Banned? Protecting the Right to Therapy. Invited webinar for the International Christian Medical and Dental Association. Simultaneously translated into Mandarin, Arabic, and Russian. https://www.youtube.com/watch?v=1ZSd1fmcvZk
2021-July 17	Introducing the International Federation for Therapeutic and Counselling Choice (IFTCC) and The Highlights of the IFTCC Report on Gender to the Bulgarian Constitutional Court. The Summit (conference), Ruth Institute, Lake Charles, Louisiana.
2021-June 3	SOGIE [Sexual Orientation and Gender Identity and Expression] Challenges and Change Allowing Therapy. Interview for Media Matters,

radio podcast for the Christian Medical and Dental Associations (USA). https://cmda.org/cmda-matters/

2020-Nov. 28 Protecting the Right to Therapy. Updated and invited presentation, virtual conference of the International Federation for Therapeutic and Counselling Choice.

2020-Nov. 28 Same Sex Attraction and Childhood Gender Dysphoria May Have Treatable Psychological Causes. Updated and invited presentation, virtual conference of the International Federation for Therapeutic and Counselling Choice.

2020-Nov. 28 'Tools in the Toolbox": Refining and promoting best practices in supporting SAFE-T (sexual attraction fluidity exploration in therapy)? Plenary panel presentation and discussion. Michael Gasparro (U.S.), Dr. Laura Haynes (U.S.), Dr. Julie Hamilton (U.S.), Dr. Melvin Wong (U.S.), Dr. Mike Davidson (U.K.), Dr. Ann Gillies (Canada), Dr. (med) Keith Vennum (U.S.).

2020-Nov. 27 Politics and Society: Therapy bans, "equality" legislation, civil unions, and imposed sex education: How do we strive for freedom, maintain rights and promote self-determination in our work and witness: Plenary panel presentation and discussion. Dr. Melvin Wong (U.S.), Roger Kiska (U.K.), Dr. Laura Haynes, (U.S.), Walt Heyer (U.S.), Dr. Ann Gillies (Canada), Alexis Lundh (Norway).

2020-Nov. 27 Science and Research: Skewed sampling, ideological monocultures and viewpoint discrimination: How is ideology masquerading as science—how do we tackle the misuse of scientific data? Plenary panel presentation and discussion. Dr. (med) Andre Van Mol (U.S.), Agnieszka Marianowicz-Szczygief (Poland), Dr. Laura Haynes (U.S.), Dr. Julie Hamilton (U.S.), Dr. (med) Peter (U.K.), Dermot O'Callaghan (U.K.), Dr. Christopher Rosik (U.S.A.).

2020-Sept. 26 Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes—and Other Confessions of the American psychological Association—Updated. Invited plenary presentation, conference of the Catholic Medical Association, Philadelphia, Pennsylvania.

2020-April 3 Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes, Change allowing Therapy is Non-Aversive—and Other Confessions of the American psychological Association—Updated. Webinar, Catholic Psychotherapist Association.

2019-Nov. 16,17	Workshop on Protecting the Right to Therapy, a repeated workshop, also panel Q&A of speakers. Conference, International Federation for Therapeutic and Counselling Choice, Hungary. Trained therapists, formerly LGBT identified individuals, and others from 25 nations in protecting the right to change-allowing therapy in their countries.
2019-Nov. 16	Protecting the Right to Therapy. Conference plenary presentation, International Federation for Therapeutic and Counselling Choice, Hungary.
2019-Sept. 27	Trending Issues: Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes—and Other Confessions of the American Psychological Association, Updated, Alliance for Therapeutic Choice and Scientific Integrity. Convention, Phoenix, AZ
2018-Nov. 19	Sexual Attraction is Not Biologically Determined, Changes, and May Have [Treatable] Psychological Causes; Change Therapy Uses Non-Aversive Methods—and Other Confessions of the American Psychological Association. Convention, Catholic Social Workers National Association, Washington D. C.
2018-Oct. 15	Protecting the Right to Therapy in the United Kingdom." Invited presentation, International Federation for Therapeutic and Counseling Choice, London, UK, https://youtu.be/SHzCAFi6NWU
2018-Sept. 21	"Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes, and Other Confessions of the American Psychological Association." Convention, Catholic Medical Association convention, Dallas TX, https://nsp.performedia.com/cma/aec18/welcome#/ then scroll to choose 9/21/2018, scroll to choose Laura Haynes, Ph.D. talk).
2017-Sept. 20	Panel Presentation on the National Task Force for Therapy Equality, May 2, 2017, "Report to the Federal Trade Commission; In Their Own Words: Lies, Deception, and Fraud—Southern Poverty Law Center, Human Rights Campaign, and National Center for Lesbian rights' Hate Campaign to Ban Psychotherapy for Individuals with Sexual and Gender Identity Conflicts." Conference, Alliance for Therapeutic Choice and Scientific Integrity, Salt Lake City, Utah.
2015-2016	Several oral testimonies presented to the Board of the California Association of Marriage and Family Therapists on various proposed organization position statements on treating undesired same sex attraction.

PUBLICATIONS AND SUBMISSIONS (past 10 years):

2020	Reviewer, *Journal of Marriage and Family*
2019ff	Reviewer, *Journal of Human Sexuality.*
2011-2018	Reviewer, *Linacre Quarterly.*
1997ff	Guest Reviewer, *Journal of Psychology and Theology.*
2012-present	Various written testimonies submitted to legislative hearing committees in several US states on proposed legislation and to city councils on proposed ordinances.
2025-1-9	Full Expert Report on The Coalition Against Conversion Therapy Memorandum of Understanding on Conversation Therapy in the UK. (book)
2025-1-9	Summary Expert Report on The Coalition Against Conversion Therapy Memorandum of Understanding on Conversation Therapy in the UK.
2024-10	(English) Marianowicz-Szczygiel A., Margasinski A., Haynes L., Smyczynska J., van Mol A. Pietruszewski K., Próchniewicz J., Chazan B., Wozinska K., Chochel K., Białecka B., Kolodziejczyk A. (2024). Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues. Association of Christian Psychologists in Poland, Warsaw. https://www.spch.pl/wp-content/uploads/2024/10/2024-SPCh-Standards_03.pdf (Polish) Marianowicz-Szczygieł A., Margasiński A., Haynes L., Smyczynska J., van Mol A., Pietruszewski K., Próchniewicz J., Wozinska K., B. Chazan, Chochel K., Białecka B., Kołodziejczyk A. (2024). Standardy i wytyczne Stowarzyszenia Psychologów Chrześcijańskich w zakresie diagnozy oraz terapii dzieci i młodzieży z problemami identyfikacji płciowej. Warszawa: Stowarzyszenie Psychologów Chrześcijańskich. https://www.spch.pl/zespol-spch-ds-plci-i-seksualnosci/
2024-4-2	IFTCC Submission to Ending Conversion Practices in Scotland: Consultation—Opposed. https://iftcc.org/iftcc-submissions-to-scotlands-conversion-practices-consultation/
2024-3-15	Haynes, L., Sullins, P., & Rosik, C. The IFTCC Is Specially Positioned to Help the Government Fulfill Its Plan to Improve the Lives of All People of Sexual or Gender Diversity in the United Kingdom Without Exception.

2024-2-6	Response to Emily Sargent's "Invited" Investigation in the Times on Former LGB-Identified Persons Who Benefit from Change Allowing Therapy. https://core-issues.org/response-to-emily-sargents-invited-investigation-in-the-times-on-former-lgb-identified-persons-who-benefit-from-change-allowing-therapy/
2024-1-31	Submission of the IFTCC to the World Health Organisation: A Guideline for Adult Hormone Treatment Would Be Scientifically Unfounded and Premature. https://iftcc.org/submission-of-the-iftcc-to-the-world-health-organisation/
2023-6-19	IFTCC Testimony Opposing California AB 665 Minors Consent to Treatment – Politicians Will Take Children Away From Parents—Letter to California Senators.
2023-Feb. 13	IFTCC Testimony Opposing Oregon HB2458 Therapy Ban Bill for Adults. https://archive.iftcc.org/testimony-opposing-oregon-hb2458-therapy-ban-bill/
2023-Jan 16	Testimony of the International Federation for Therapeutic and Counselling Choice in Opposition to Therapy Ban Bill HF16 in the State of Minnesota, U.S.A. https://archive.iftcc.org/testimony-opposing-minnesota-hf16-therapy-ban-bill/
2022	Davidson, M., Haynes, L., James, S., & May, P. An International Declaration on "Conversion Therapy" and Therapeutic Choice. https://iftcc.org/the-declaration/
2022	Davidson, M., Haynes, L., James, S. Extract from the submission to the U.K. Government's Consultation on Conversion Therapy. https://archive.iftcc.org/extract-from-the-submission-to-the-uk-governments-consultation-on-conversion-therapy/
2022-Sept 9	Open Letter to the U.S. Department of Education from the IFTCC—The DOE's Intention to Coerce Gender Ideology Compliance in Schools by Changing Title IX Will Have Seriously Harmful Consequences. https://archive.iftcc.org/open-letter-to-the-us-department-of-education-from-the-iftcc-the-does-intention-to-coerce-gender-ideology-compliance-in-schools-by-changing-title-ix-will-have-seriously-harmful-consequences/
2022-May 3	San Diego County, California, U.S.A. Proposed Ordinance Based on the U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) While Defining Woman by Gender Identity—Opposed. IFTCC Testimony Submitted to the San Diego Board of Supervisors. https://archive.iftcc.org/haynes-l-may-3-2022-san-diego-county-california-u-s-a-proposed-ordinance-based-on-the-u-n-convention-on-

the-elimination-of-all-forms-of-discrimination-against-women-cedaw-while-defining-wo/

2021-Sept. 24 Matters Arising from Questions put to the IFTCC Oral Presentation on Thursday 23rd September 2021. IFTCC letter to the Justice Select Committee of the New Zealand Parliament. https://archive.iftcc.org/letter-to-new-zealand-justice-select-committee-24th-september-2021/

2021 Sept. 8 IFTCC Submission to New Zealand Government's Proposed "Conversion Practices Prohibition Legislation Bill" September 2021. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2021/09/IFTCC-Submission-to-NZ-MPs-Opposing-Conversion-Practices-Prohibition-Bill-2021-9-7-4-pp-with-endnotes-.pdf?x86993

2021-June 19 International Federation for Therapeutic and Counselling Choice expert opinion on the constitutional meaning of "sex" and "gender": Medical gender affirming treatment, Case no. 6 of 2021, Bulgarian Constitutional Court. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2021/07/IFTCC-Brief-for-Cassian-Constitutional-Courts-in-Bulgaria-on-Gender-2021-6-19-FINAL-Full-edits-English-Post-2021-7-2-.pdf?x28941

2021-April 20 Davidson, M. & Haynes, L. for the IFTCC Science and Research Council. Letter to Doug Beattie, MLA North Ireland Assembly, on "Conversion Therapy".

2021 Williams, W.V., Brind, J., Haynes, L., Manhart, M.D., Klaus, H., Lanfranchi, A., Migeon, G., Gaskins, M., Seman, E.I., Ruppersberger, L., Raviele, K.M. (2021). Hormonally active contraceptives, part II: Risks acknowledged and unacknowledged, *The Linacre Quarterly,* in press. https://doi.org/10.1177/0024363920982709

2021 Williams, W.V., Brind, J., Haynes, L., Manhart, M.D., Klaus, H., Lanfranchi, A., Migeon, G., Gaskins, M., Seman, E.I., Ruppersberger, L., Raviele, K.M. (2021). Hormonally active contraceptives, part I: Risks acknowledged and unacknowledged, *The Linacre Quarterly,* online, 1-23. https://doi.org/10.1177/0024363920982709

2020-Spring Uncovering treatable causes of same-sex attraction and childhood gender dysphoria. *The Pulse* (an online publication of the Catholic Medical Association).

2019-Dec. 21 Davidson, M.R., Rosik, C., Moseley, C., and Haynes, L. Submission to Victor Madrigal-Borloz Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity. For

	consideration towards a Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity with focus on practices of so-called "conversion therapy" to the 44th Session of the Human Rights Council. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2019/12/IFTCC-to-UN-HRC-individual-Submission-to-Victor-Madrigal-FINAL-2019-12-21.pdf?x13266
2019-Nov. 17	Contributing author: International Federation for Therapeutic and Counselling Choice Declaration - 2019 (Nov. 17, 2019), https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2019/11/IFTCC_Postconference_Statement_2019_English.pdf?x91403
2018-Sept. 21	The American Psychological Association Says Born-That-Way-and-Can't-Change Is Not True of Sexual Orientation and Gender Identity—Updated. https://www.acpeds.org/wordpress/wp-content/uploads/8.21.17-APA-Handbook-Born-That-Way-Not-True-16-9-21-Haynes-Update.pdf
2019-Sept. 16	"Are Religious Californians Really Harming the Mental Health of People Who Identify as LGBTQ?" Essay at Public Discourse. https://www.thepublicdiscourse.com/author/laura-haynes/
2019-May 16	Haynes, L. & Rosik, C.H. "Comment on Proposed Updated APA 'Resolution on Sexual Orientation Change Efforts,'" submitted to the Society for the Psychology of Sexual Orientation and Gender Diversity and the Committee on Sexual Orientation and Gender Diversity that drafted the proposed updated position statement on sexual orientation change efforts for the American Psychological Association. 99 pages.
2018 to present	Letters/Fact Sheets to federal, state, county, and city lawmakers and agencies on sexual orientation/gender identity and religious freedom laws and policies. Example: TherapyEquality.org/HarmsOfTherapyBans (periodically updated).
2016-Sept. 27	The American Psychological Association Says Born-That-Way-and-Can't-Change Is Not True of Sexual Orientation and Gender Identity. Published online by professional, religious, ministry, and activist organizations. Example: https://www.therapeuticchoice.com/important-research-articles
2015-2016	(2015-Sept/Oct), (2016-Jan/Feb), (2016-July/August) Letters to the Editor, *The Therapist*, a periodical of the California Association of Marriage and Family Therapists. Urging the Board to end its censoring positions in opposition to therapy that is open to sexual orientation change.