CHANGED
MOVEMENT

# The Unspoken Harms of Banning Change.

*Psychological pain underlies the LGBTQ experience.*
*Why acceptance, equality and affirmation won't be enough.*

**WHY WRITE THIS**

• There is no widely accepted legal definition of so-called "conversion therapy." In fact, legislative bans do not rely on population wide, evidence-based studies. An honest definition for use in law could be: "conversion therapy is any counseling practice that overrides personal consent and employs aversive techniques to affect sexual behaviors."

• The furor over "conversion therapy" stifles free speech by condemning talk-based approaches that focus on personal life goals. Ethical, talk-based, change-allowing counsel addresses confusion, trauma, clinical gender dysphoria, childhood abuse and shame. Suppression of the story behind LGBTQ experience has created a myth that denies underlying pain and trauma. The world-wide "anti-conversion therapy" tirade has effectively become state-sanctioned viewpoint discrimination.

• In every debate over so-called "conversion therapy" religion and faith-based sexual ethics are challenged, suppressing the sexual ethic itself and threatening to harm LGBTQ identifying people who seek support to follow their personal convictions.

**Beginning in 1970, political activists protested against the APA and began disrupting their meetings based upon the belief that the APA was largely to blame for anti-homosexual social stigma.**

**CHANGED** *is a grassroots network of people who once identified as LGBTQ.*

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## A look at the "conversion" of the American Psychological Association

The drama around so-called "conversion therapy" is not new. In fact, Americans have seen all this before… in the 1970s as LGBTQ activists first began attacking therapeutic approaches to homosexuality.

Political pressure by early activists resulted in the removal of homosexuality from among the American Psychiatric Association's listing of diagnoses. In the same way today, Christianity is in the crosshairs. Will prohibitions against homosexual practice be removed from the Bible? Or worse, will Christianity, with its historic teaching on male-female marriage be banned? That seems to be the direction progressive activists are headed. Conversations focusing on the efficacy of so-called "conversion therapy" reveal a legacy of moral questioning that modern psychology and Christian faith have grappled separately with for decades. Central to the debate is a conundrum that continues to linger: should homosexual behavior have a protected status when the feelings may shift, can be reduced or even eliminated; and which also incorporate psychological co-morbidities and physical disease?

To better understand, it's helpful to observe America's recent history with this problem. After Stonewall in 1969 and the beginning of the early LGBTQ civil rights movement, activists demanded that homosexuality be removed from the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM), its formal listing of psychological diagnoses. Up to that time, homosexuality had been classified as a pathology, or a mental illness, in the DSM. Beginning in 1970, political activists protested against the APA and began disrupting their meetings based upon the belief that the APA was largely to blame for anti-homosexual social stigma.

> Charles W. Socarides, M.D. was a psychiatrist during this time who addressed homosexuality in his private practice and as a university instructor. He records,"Those of us who did not go along with the political redefinition were soon silenced at our own professional meetings. Our lectures were canceled inside academe and our research papers turned down in the learned journals… Mainstream publishers turned down books that objected to the gay revolution."[1]

By 1973, the public pressure on the American Psychiatric Association's leaders ultimately resulted in their desired outcome: declassifying homosexuality as a socio-pathological disease. In 1975, the American Psychological Association followed the American Psychiatric Association in declaring homosexuality was not pathological. In the DSM-II homosexuality was replaced with the phrase, Sexual Orientation Disturbance (SOD), which applied to individuals who were conflicted over their

*According to the CDC in 2018, "Gay and bisexual men accounted for 69% of all new HIV diagnoses among all males aged 13 and older in the United States."* [16]

*In 2014, gay, bisexual, and other men who have sex with men accounted for 83% of primary and secondary syphilis cases.*[17]

*According to the Human Rights Campaign, 21% of gay and lesbian youth and 22% of bisexual youth have attempted suicide, compared to 7% of straight youth.*[18]

*"Individuals with documented histories of childhood sexual abuse were significantly more likely … to report ever having had same-sex sexual partners."*[19]

homosexual feelings. It was hoped that this move would improve the rights of LGBTQ-identifying people. But it did not immediately change the professional, scientific opinion. A survey of 10,000 APA members in 1977[2] records that 69% of responding psychiatrists continued to believe homosexuality was disordered ("a pathological adaptation") despite this change. Then, in 1980, "Ego Dystonic Homosexuality," replaced SOD with the publication of the DSM-III. However, that was finally removed in 1987.

Professional psychology and psychiatry were undergoing changes. The professions themselves, as well as the history of psychological diagnostics, were being scrutinized by society.[3] A re-evaluation of what constitutes psychopathology was underway, and it was concluded that homosexual behavior was not disordered. That is, it did not negatively impact a person's ability to function interpersonally or as a contributor to society. A close look at the restructuring of the science of psychology of homosexuality as a result of the upheaval of the 1970s could provide clues to where culture (and especially Christianity) is headed.

The political pressure that removed homosexuality from the DSM continued to cause a very great shift in how psychologists addressed homosexuality. No longer considered abnormal or harmful according to their evaluative standards, psychologists would have less reason to address it. And, because mental health insurance coverage demanded diagnoses according to the DSM, any treatment for homosexuality was defunded. As a result of ongoing activism within these professions, the psychology of homosexuality has had an affirming bias ever since.

The American Psychiatric Association and the American Psychological Association redirected psychological training in how homosexual behavior was addressed. Though psychological and biological study of homosexuality continued, attempts to resolve or redirect sexual orientation were excluded. Very simply, a vacuum was created, in which in-depth and exhaustive study of orientation change was dis-empowered, marginalized, and even discredited because of ongoing gay activism. Little professional training or research has been focused on the topic. Research continues to be conducted, and treatment methods continue developing, but fewer professionals providing therapy for sexual orientation change are receiving advanced training.

**Highlighting social stigma rather than mental health as primary causation for suicide rates harms the LGBTQ community by misdirecting prevention and care.**

In the nearly 50 years since declassifying homosexuality as a disorder, advances in psychological care have greatly expanded. Psychological health and the sciences around it have become a central factor in modern self-care. What we know about trauma care and bodywork, neurofeedback, psycho pharmacology, neuroplasticity, and changing our neural pathways is so much more advanced than in the 1970s. The reality is that, unfortunately, LGB-identifying people have suffered from the exclusion of homosexuality from the DSM. They have not benefited from advances in areas where research and care could be most impactful: sexual formation. And rates of suicide, co-occurring mental health issues, and maladaptive behaviors continue to remain high, pointing directly to the poor mental, behavioral, and relational health of those who experience same-sex attraction and gender confusion. Highlighting social stigma rather than mental health as primary causation for suicide rates harms the LGBTQ community by misdirecting prevention and care.

**19x**
higher suicide rate **after** gender-reassignment[4]

This same avoidance by the APAs is also evident in approaches to gender identity (T), which failed to stem even higher rates of emotional instability among the transgender-identifying population. There are even more severe consequences as individuals are directed to physically modify their bodies for the sake of mental well-being. Today, transgender identifying adults are 19x more likely to commit suicide *after* gender-reassignment.[4] Culture's embrace of these life-altering paths, partnered with the intentional indoctrination of young children to question their gender, is a Pandora's box.

**"Conversion Therapy Bans" harm children who experience gender dysphoria.**

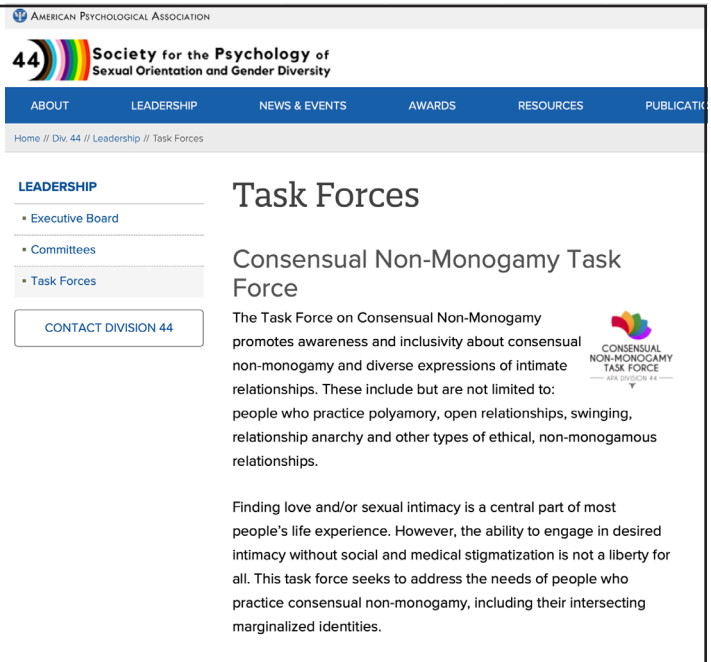
According to The Trevor Project, forty-one states today ban counseling choice or have pending "anti-conversion therapy" legislation focusing on minors. Based upon misleading claims of harm and errant scientific data, these bans inhibit free speech and freedom of conscience for thousands who are seeking alternatives to LGBTQ experience. So-called "conversion therapy bans" preempt a licensed therapist from offering change-allowing counsel (reflecting statistical norms toward desistance) that can bring resolution to trauma among gender dysphoric children. **Conservatively, 85% of children who are appropriately affirmed in their biological sex (an approach called "watchful waiting") will desist by adulthood.**

What we presume is impossible, according to the APAs is based upon nearly a half century-year-old supposition. Because of ideological changes and shifts, the APAs have seemed under motivated to investigate causes of homosexuality and of the mental health problems of this population. So, even though the APAs are some of the biggest advocates for the LGBTQ community, in our opinion the APAs share blame for the ongoing (even increasing) suicidality, mental, physical and relational

**Trusting the APA?** As the American Psychological Association becomes more politicized it has taken radical approaches to sexuality. For example, **the APA Handbook of Sexuality and Psychology (2014) says it may be time to say BDSM is normal—meaning bondage and discipline, dominance and submission, and sado-masochism.**

"It may be time to consider alternate ways of understanding BDSM outside of models of psycho-pathology. Certainly, the descriptions by BDSM practitioners in the community literature suggest that their activities are experienced as life affirming, growth enhancing, and intensely erotic (Califia, 2002; Taormino, 2012; Thompson, 2004). The few clinical illustrations of BDSM couples in sex therapy have suggested that being true to one's own desires in a relationship can eventuate in profound self-knowledge and a sense of coming home and can be transformative (Kleinplatz, 2006)" (p. 251).

-Kleinplatz, P. & Diamond, L. (2014) Chapter 9: Sexual diversity. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches. Pp. 245-267. Washington D.C.: American Psychological Association. https://www.apa.org/pubs/books/4311512.




issues suffered by LGBTQ-identifying people. Psychiatry and psychology appear to have completely abandoned LGBTQ-identifying people in their pursuit of social normativity—except to affirm homosexuality as "natural" and "good."

## Born this way? Certainly not.

**To date there is no scientific consensus on the cause of homosexual behavior.** As gene studies continue to fail to explain sexual orientation, there should be a growing discussion of the environmental and cultural factors that lead to homosexual behavior. Notably in the most recent gene study (of 493,000 people over 30 years) *Science Magazine* writes,

> "...although they did find particular genetic loci associated with same-sex behavior, when they combine the effects of these loci together into one comprehensive score, the effects are so small (under 1% [of sexual behavior for our total population]) that this genetic score cannot in any way be used to predict same-sex sexual behavior of an individual... Ganna et al. did not find evidence of any specific cells and tissues related to the loci they identified... this study serves as a guide to the potential magnitude of genetic effects we may eventually measure and a sign that complex behaviors continue to have small, likely polygenic, influences. Future work should investigate how genetic predispositions are altered by environmental factors, with this study highlighting the need for a multidisciplinary sociogenomic approach."[5]

**"...not only did the study fail to find some controlling gene for gay identity, it also established that gay persons are not genetically distinct from all other human beings in any meaningful sense."**

The environmental factors that influence one's sense of identity and corresponding sexual expression are a central focus in the efforts that LGBTQ activists call "conversion therapy." All of us who have successfully left behind LGBTQ identity and behaviors, even experiencing shifts in sexual desires, have focused largely on childhood emotional development and cultural factors such as peer pressure, bullying and isolation. We have gone so far as to recognize that we are simply normal men and women. This is substantiated by Ganna's study. It exposes the truth that homosexual men and women have the same genome as everyone else.

> "The study found that a person's developmental environment—the influence of diet, family, friends, neighbourhood, religion, and a host of other life conditions—was twice as influential as genetics on the probability of adopting same-sex behaviour or orientation. The genetic influence did not come from one or two strong sources but from dozens of genetic variants that each added a small increased propensity for same-sex behaviour.
>
> A genetic arrangement based on a large number of markers across the genome means that virtually all human beings have this arrangement, or large portions of it. In other words, not only did the study fail to find some controlling gene for gay identity, it also established that gay persons are not genetically distinct from all other human beings in any meaningful sense. **Gay persons, we might say, have a perfectly normal human genome."**[6]

**Most people who experience same-sex sexual attraction also already experience opposite-sex attraction.**

Mainstreaming the LGBTQ narrative into culture today has caught our common imagination and is effectively increasing the number of people who identify as a sexual minority. In February 2021, Gallup[7] released a poll describing the population of LGBTQ identifying people. Their conclusions reveal the impact of culture's increasing affirmation of LGBTQ culture and experience. More and more people are describing themselves as LGBTQ. Gallup's poll indicates that **over the last 7 years (2012-2020) the number of men and women identifying as LGBTQ increased 60%**. The generational shift in self-ascribed LGBTQ identity is dramatic: 15.9% of Generation Z (b1997-2002) identify as LGBTQ; 9.1% of Millennials (b1981-1996); 3.8% of Generation X (b1965-1980); and 2.0% of Baby Boomers (b1946-1964).

Changes in sexual behavior, identity, and even attractions *do happen* for many. This reflects the overall tendency of our culture toward sexual fluidity. The majority of people who experience LGB have experienced opposite sex attraction as well. In the APA Handbook on Sexuality, on behalf of the APA, Dr. Lisa Diamond states, "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." This pattern has been found internationally (v. 1, p. 633). Most people who experience same-sex sexual attraction also already experience opposite-sex attraction. The largest part of LGB is bisexual and the APA has published that among these, three-quarters (75%) will typically move toward heterosexual over time.

> The APA Handbook reviews a highly regarded study by gay researcher Savin-Williams and colleagues (Savin-Williams, Joyner, & Rieger, 2012; Rosario & Schrimshaw, 2014, APA Handbook, v. 1, p. 562) that followed the sexual identity of young adult participants when most were ages 18 through 24 and again at ages 24 through 34, about 6 years later. Participants indicated whether their sexual identity was heterosexual, mostly heterosexual, bisexual, mostly homosexual, or homosexual. The bisexual group was larger than exclusively gay and lesbian groups combined. But the largest identity group, second only to heterosexual, was "mostly heterosexual" for each sex and across both age groups, and that group was "larger than all the other non-heterosexual identities combined" (Savin-Williams et al., 2012, abstract). "The bisexual category was the most unstable" with three quarters changing that status in 6 years. "[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality" (p 106). Similar change is found in other population-based longitudinal studies, and rates of change do not appear to decline as participants get older (Diamond & Rosky, 2016, p. 7, Table 1). Kleinplatz and Diamond urge in the handbook that "it is critically important for clinicians not to assume that any experience of same sex desire or behavior is a sign of latent homosexuality and instead to allow individuals to determine for themselves the role of same-sex sexuality in their lives and identity" (p. 257)[8]

LGBTQ activists would prefer to believe same-sex sexual feelings are fixed and innate and settle the matter through biology, yet science has never supported that idea. And, since the APAs continue to steadfastly downplay the degree to which sexual behavior and gender identity (like gender stereotypes) are shaped by cultural and environmental factors, there is an impasse.

**The phrase "conversion therapy" has gained meaning well beyond any reference to counseling or therapy and reflects a growing ideological shift.**

## Origins and impact of the phrase "Conversion Therapy"

We believe the term "conversion therapy" marries 1970s anti-APA rhetoric and oppressive international anti-conversion laws. Across the world, most notably in India, anti-conversion laws support nationalism by suppressing minority religions. For example, Christianity and Islam are the two primary targets of Hinduism, India's majority (national) religion. The term "conversion therapy" combines LGBTQ activist animosity against therapeutic practices and religious faith; both are targets because they can powerfully and reasonably argue that homosexual "identity" should not be awarded protected status. Anti-conversion therapy legislation and like-minded rhetoric seek to justify a cultural dynamic. Activists are fighting for the right to exist as a minority people group and to strengthen the LGBTQ subculture. As they do, they seek to shut down all opposing voices through slander and censorship.

> "Time and time again, persons who reverse the healing path and embrace the LGBTQ lifestyle re-write their therapeutic histories as coercive to the point of caricature. We… have witnessed this in churches and courts and government councils around the country. We've felt the impact of it in bad rulings that outlaw a person's right to choose their therapeutic path. We conclude: the moral reversal into LGBTQ identification necessitates skewed self-justification. Orthodox caregivers become the enemy."[9]

In most cases where practices are denigrated as so-called "conversion therapy" only a change-allowing and exploratory approach based upon talk-therapy is being applied. The intent is largely an effort to

**Key studies used to ban counseling choice reflect significant bias.**

bring relational wholeness and wellbeing to people who experience *undesired* same sex attraction. Those who seek this counseling wish to be incorporated into broader society without the LGBTQ label. Change allowing approaches address the "environmental factors" that the latest gene studies point to. One of the primary emotional dramas of the LGBTQ experience is perceived rejection. Many feel "other than" and "unable to belong." A very great strength of the LGBTQ subculture is the feeling of belonging and familial safety that it cultivates. Laws such as HR-5, The Equality Act, create a tenuous salve for this sense of rejection.

Increasingly the phrase "conversion therapy" has gained meaning well beyond any reference to counseling or therapy and reflects a growing ideological shift. Over 150 different definitions exist in legislation across the world. The phrase is widely being used where there is ideological conflict on sexuality to defame and harm persons or organizations with a different viewpoint. Quite simply, it is becoming state-sanctioned viewpoint discrimination.

### Under scrutiny, claims of evidence-based and peer-reviewed data on the impact of sexual orientation change efforts (SOCE) have been exposed as inaccurate.

Some of the strongest indictments against claims of harm come from two studies published in spring 2021. In June 2020 the American Journal of Public Health published a study led by John R. Blosnich[10]. The Generations study has been used widely to condemn sexual orientation change efforts (SOCE). Note that the scientists behind this study show a conflict of interest:

> John R. Blosnich is with the Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, PA. Emmett R. Henderson and Robert W. S. Coulter are with the Center for LGBT Health Research and the Department of Behavioral and Community Health Sciences, University of Pittsburgh Graduate School of Public Health, Pittsburgh. Ilan H. Meyer is with the Williams Institute, School of Law, University of California, Los Angeles.

They concluded, "Over the lifetime, sexual minorities who experienced SOCE reported a higher prevalence of suicidal ideation and attempts than did sexual minorities who did not experience SOCE." But when the data was made public a group of scientists reassessed them. In his essay[11] on the Christian Medical and Dental Association website, Dr. Andre Van Mol recounts:

**Using the same data, but controlling for pre-SOCE suicidality, a completely different outcome was discovered: SOCE was found to strongly *reduce* suicidality.**

> A response letter led by Christopher Rosik (including Paul Sullins, Walter Schumm and me) was also published in the American Journal of Public Health.[12] Three main study flaws were noted. First, the authors lumped adverse childhood events as a total sum, including SOCE as one. Second, they should have considered whether those seeking SOCE did so due to already being more distressed. With no pre-SOCE control for existing suicidality, it was speculative for Blosnich to suggest SOCE caused harm. And third, the Generations study sampled only LGBT-identified individuals—therefore excluding sexual minorities who benefited from SOCE, thus no longer identifying as LGBT—and used "a single-item measure of SOCE" which was "fraught with validity concerns." Blosnich and team provided a rebuttal letter I would call dismissive.
>
> Paul Sullins put together a thorough reanalysis of the Generations and Blosnich data, including what was available to Blosnich but left out, "the time order of SOCE and suicidality," thus controlling for pre-SOCE suicidality.[13] Sullins concluded, "By violating the principle of temporal precedence in scientific inference, i.e., that a cause cannot occur after an effect, Blosnich et al. reversed the correct conclusion in these data." In fact, "SOCE was not positively associated with any form of suicidality." SOCE strongly reduced suicidal ideation, planning and attempts, with even stronger effects for adults experiencing SOCE compared with minors doing the same.
>
> Sullins found that over half of those said to have had SOCE had pre-treatment suicidality, SOCE helped rather than harmed, and the degree of improvement was remarkable. Post-SOCE suicidal ideation odds went down by two-thirds for adults and one-third for minors. Post-SOCE reduction in suicide attempts was by four-fifths for adults with no reduction for minors. "When followed by SOCE treatment, suicide ideation was less than a fifth as likely to lead to a suicide attempt; suicide planning less than a seventh as likely; and an initial suicide attempt was over a third less likely to lead to second attempt. 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 17-25 times less likely to attempt suicide."

In reality, there have been no rigorous population based scientific studies of the impact of SOCE. The studies being used to substantiate legislation across the U.S. are not adequate. Notably, very few studies analyzing change allowing therapies incorporate women, whose sexuality is known to be more fluid. In

**The push for "conversion therapy" legislation empowers state-sanctioned viewpoint discrimination.**

2009 the American Psychological Association SOCE Task Force concluded there simply is no adequate analysis of its benefits or harms.[14] This is still true. In 2019 a Florida court recently summarized the expert consensus on research in this area in two statements: "No known study has provided a comprehensive assessment of basic demographic information, psychosocial wellbeing, and religiosity, which would be required to understand the effectiveness, benefits and/or harm caused by SOCE." "No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE"[15] (Ruling in Vazzo v. Tampa, October 4, 2019, striking down a ban on talk conversion therapy).

## Do you believe LGBTQ-identifying people should have the right to follow their faith wholeheartedly and pursue their own life goals?

*"Conversion therapy" is a broad and ill-defined term that is often used to suggest forms of physical violence, force, manipulation, shame, or humiliation. We reject these practices as ineffective and harmful. Conversely, change-allowing approaches among self-motivated individuals affirm personal choice and empower individual life goals that are commonly aligned with religious sexual ethics.*

Most often, so-called "conversion therapy" isn't a therapeutic method, it is a subjective experience that can be avoided. Two people pursuing emotional healing and physical wholeness in the same setting may have different perceptions. One finds meaning in what is learned, and through application undergoes some fresh measure of fulfillment. But imagine the other has a less productive outcome and finds no resolution. Disappointment and despair close in. Accusations of harm and pain arise from this side of the experience. Note how few legal cases there have been versus the thousands of accusations.

Increasingly in the U.S., former LGBTQ-identifying people are being pushed into the margins. Anathematized by activists through public scrutiny and shaming, Christian organizations focused on care for former LGBTQ easily become isolated and attacked. The history of ex-gay ministries reveals the dramatic negative impact of these attacks as a few outspoken former leaders have sought refuge and self-justification by rejoining LGBTQ ranks.

Ultimately, bias, censorship and slander are misleading thousands of people. Many today are trapped within an unwanted experience that has falsely been represented as innate. A battle focusing on social stigma is not the answer and is effectively increasing suicidality among LGBTQ.

**He walked away from an "identity" that otherwise would have tethered him to a cycle of unresolved trauma—reenacting in each male encounter the very things he had been abused by.**

**This crisis in America's scientific and psychological communities is a travesty.**

The LGBTQ storyline oversimplifies the truth. For example, somewhere in the development of stereotypically effeminate mannerisms is a decision that one's understanding of femininity feels more comfortable, safe or attractive than his perception of masculinity. Many have analyzed that personal experience to understand there are patterns of belief and self-rejection around effeminate behaviors, and eventually have fully embraced masculinity—leaving the mannerisms behind. Like David Reece:

> "I had been molested as a child at 3-years-old and experienced same-sex attraction from a really early age. I was disconnected from the male gender... I didn't feel like other boys. I dressed in girls clothes, wore my sister's dresses and I played with barbies exclusively.[20] (In my 20s,) I started counseling sessions that helped me get out of pain and confusion and understand that just because I was molested at three didn't mean I was gay... Before I walked out of same-sex attraction, I only knew fake happiness. Today my life is crazy good and full of joy."[21]

David has been married to his wife since 2010 and they have two children together. Not all LGBTQ identifying people have been molested; however, too often they are led to dismiss symptoms of trauma. Addressing the associated emotional pain in David Reece's life changed his affections. He walked away from an identity that otherwise would have tethered him to a cycle of unresolved trauma—reenacting in each male encounter the very things he had been abused by.

**Today, the pastoral care and counseling David received is being criminalized across the world and potentially in the U.S. Men like him are pressured to embrace gay identity and told that resistance points to inner homophobia. This approach creates a false narrative that perpetuates lifelong unresolved pain. People should have the freedom to pursue counseling and personal life changes that bring them true happiness even when it means moving away from LGBTQ identity and behavior.**

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# "Conversion Therapy Bans" harm children who experience gender dysphoria.

So-called "conversion therapy bans" preempt a licensed therapist from offering change-allowing counsel (reflecting statistical norms toward desistance) that can bring resolution to trauma among gender dysphoric children.

## Conservatively, 85% will desist by adulthood

*Studies overwhelmingly concur that DESISTANCE is the norm for childhood gender dysphoria, unless affirmed:*

DSM-5 p.455: lists rates of persistence translate to rates of desistance in natal males from 70 to 97.8% and natal females from 50 to 88%. [1]

American Psychological Association Handbook on Sexuality and Psychology,V1,744[2]: *"In no more than about one in four children does gender dysphoria persist from childhood to adolescence or adulthood..."* That represents a minimum 75% rate of desistance.

Cohen-Kettenis, 2008, J SexMed: 80-95% of gender dysphoric pre-pubertal children desist by the end of adolescence. [3]

Ristori, et al Int Rev Psychiatry 2016: Finding a desistance rate of 61-98% of GD cases by adulthood.[4]

The pro-affirmation Endocrine Society Guidelines admit: "... the large majority (about 85%) of prepubertal children with a childhood diagnosis (of GD) did not remain gender dysphoric in adolescence." [5]

U of Toronto psychologist Dr. Ken Zucker summarizes and defends the numerous studies showing desistance is common in his 2018 paper, "The myth of persistence." [6]

## Suicide rates increase, not decrease, after transition[14] [15]

A 2011 Swedish study of post-gender-reassignment adults showed a suicide rate 19 times that of the general population 10 years out. Also, nearly 3 times the rate of overall mortality and psychiatric inpatient care. This was a 30-year population-based matched cohort study of all 324 sex-reassigned persons in Sweden. [7]

**19x**
higher suicide rate **after** gender-reassignment

## A patient... for life

A patient who undergoes gender transitioning will be a patient for the rest of their life. They incur lifelong need for sex hormones and management of their complications; surgeries, if chosen, have consequences and complication rates; as well as other shortcomings such as prohibitive financial costs. [10] [11] [16]

## A child cannot provide informed consent.

Children have a developing brain, their minds change often, and they don't grasp long-term consequences. [8]

There is ethical concern that individuals of any age fully understand the implications of gender affirming therapy, i.e. transition affirming (GAT/TAT), but especially children. Case Western Reserve's Dr. Stephen Levine's 2-part test for ethical tensions in people of all ages requesting GAT/TAT asks: "Does the patient have a clear idea of the risks of the services that are being requested? Is the consent truly informed?" Per Dr. Levine, *"The World Professional Association for Transgender Health's Standards of Care recommend an informed consent process, which is at odds with its recommendation of providing hormones on demand."* [9]

Sweden has had broad acceptance of transgender identity for decades. In May 2, 2019 the Swedish Pediatric Society issued a letter of support for the Swedish National Council for Medical Ethics' (SMER) proposal (for the Ministry of Social Affairs to systematically review treatment of youth with gender dysphoria) in which they cautioned, "Giving children the right to independently make vital decisions whereby at that age they cannot be expected to understand the consequences of their decisions is not scientifically founded and contrary to medical practice." [12]

UK High Court in Bell vs. Tavistock Dec. 12, 2020 ruled that GAT/TAT in minors was experimental — with limited evidence for efficacy and safety — and could not, in most cases, be given to minors under 16 without court order, and that such was advisable for those 16-17. They added, "There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years." [13]

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**"More than 90 percent of people who die of suicide have a diagnosed mental disorder. There is no evidence that gender-dysphoric children who complete suicide are any different."[17]**

### In the words of a licensed psychologist:

*"As a licensed psychologist (doctoral level) who works with trauma, and who has been practicing for over 15 years, I am concerned about the progressively radical position of the American Psychological Association and the counseling field in general in regard to procedures for transgender transitioning.*

*I own a medium sized practice in an area that is metropolitan and have seen many clinical situations where there has been a resistance to doing the clinical work under a desire to transition gender rather than moving to work on the underlying issue. For example, I have seen many move to gender non-binary after abuse by both mom and dad so no gender is safe. I have seen those with obsessive anxiety transition gender rather than work on the obsessive anxiety. I have seen those who have been sexually abused change gender, i.e., change sexual parts that feel vulnerable from trauma- before trauma was treated adequately. These are just a few examples. I am even more alarmed when I see how this seemingly under-scrutinized "affirm at all costs" ethos is being applied to children. The menu of genders and sexual identities keeps growing, making identify formation (already tough) even harder. Our field is so aggressively trying to be affirming that I fear we are leaving behind our ethics of "do not harm" (i.e., "Benevolence" and "Non-maleficence").*

**"I have seen those who have been sexually abused change gender, i.e., change sexual parts that feel vulnerable from trauma—before trauma was treated adequately."**

*If I had a client who hated his nose and was determined to cut it off, I would clinically see this as a serious psychological problem to be treated. I would not work with him to assess whether or not he should go through surgery to cut off his nose.*

*I respect and honor all people. I want to see trauma healed in all people. I, like all clinicians, have ethical limits regarding what I will treat."*

-Anonymous, PhD LP SEP

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[15]Studies claiming suicide reduction tend to use convenience sampling. The authoritative Handbook of Survey Methodology for the Social Sciences warns, "... you cannot make statistical generalizations from research that relies on convenience sampling." They also often violate the "association is not causation" rule. (Lior Gideon, editor. Handbook of Survey Methodology for the Social Sciences. New York: Springer, 2012. ISBN 978-1-4614-3875-5.)

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