**Written Testimony of Judith Glassgold, Psy.D in Support of L.D. 1025,
An Act To Prohibit the Provision of Conversion Therapy to Minors
by Certain Licensed Professionals**

Joint Standing Committee on Health Coverage, Insurance, and Financial Services
By Judith Glassgold, Clinical Psychologist
April 10, 2019

1. I am a licensed psychologist with over 30 years of specialization in the psychology of sexual orientation and gender. I am currently a Lecturer and Clinical Supervisor at the Graduate School of Applied and Professional Psychology of Rutgers, the State University of New Jersey, and the Director of Professional Affairs at the New Jersey Psychological Association where I provide advice on clinical and practice issues. In 1997, I was granted Fellow status in the American Psychological Association due to my expertise in sexual orientation and gender identity. I have treated hundreds of children, adolescents, and adults who have struggled with their sexual orientation and gender identity. My background, experience, and scholarly publications are summarized in my curriculum vitae, which is attached as Exhibit A.

2. I have served in leadership roles on the authoritative professional and governmental assessments of efforts to change sexual orientation and gender identity. I served as the Chair of the American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2007-2009) and co-wrote and edited the final report released in 2009, *Report of the American Psychological Association Task on Appropriate Therapeutic Responses to Sexual Orientation* (the "APA Report"), attached as Exhibit B. The APA report was undertaken to answer fundamental questions about the benefits and harms of efforts to change sexual orientation.

3. I served as one of the APA staff coordinators for the expert consensus panel that provided the basis of the 2015 report of the US Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBT Youth* (the "SAMSHA Report"), attached as Exhibit C.

4. Today it is universally recognized by every authoritative medical and mental health association throughout the world that having a same-sex sexual orientation, or a gender identity different from the one assigned at birth, are part of the normal spectrum of human experience. Decades of scientific research has shown that variations in sexual orientation and gender identity or expression are not a mental illness or developmental defect, and suggest no impairment in a person's ability to function. We also now understand that an individual's sexual orientation and gender identity are not susceptible to change and, in fact, are established at a very young age, most likely due to complex genetic, prenatal, neurological and endocrinological factors.

5. I set out below the current medical and scientific understanding of sexual orientation and gender identity and the harmful impacts of attempting to change them.[1] But before I do so, I ask you to consider a common experience of a young person who is subjected to conversion therapy practices: Assume a child or adolescent who grows up in a world that stigmatizes and devalues their identity. Assume also that this young person is told by someone presenting as a trusted professional authority that who they are and what they are feeling is so shameful, flawed and wrong that it must be eradicated. It should not surprise you that this young person will suffer from a negative self-image and identity at crucial developmental phases of life. What is even more distressing for that young person is that these change efforts will ultimately fail, increasing the

[1] The reference list at the end of the document lists sources for this testimony.

child's hopelessness and desperation. I hope that my testimony helps us all to understand the profound harm that flows from these misguided efforts.

I. Understanding Sexual Orientation, Gender Identity, and the Discredited Practice of Conversion Therapy.

6. Sexual orientation is a well-established concept in psychology. Sexual orientation refers to an enduring pattern of emotional, romantic and/or sexual attractions directed to another person. Sexual orientation is an objective, human phenomenon that can be assessed and measured. Although sexual orientation ranges along a continuum, it is usually discussed in terms of four categories: heterosexual, lesbian, gay, and bisexual. Individuals express their sexual orientation through identity and behavior. [2]

7. Gender identity is also an established concept in psychology. It is distinct from sexual orientation. Gender identity refers to a person's internal, deeply-rooted sense of one's gender.

8. Most people have a gender identity that is consistent with their assigned sex at birth. For transgender individuals, their gender identity does not match their assigned sex at birth.[3]

9. The American Psychological Association, the American Psychiatric Association and numerous other medical and mental health associations have publicly affirmed that they do not consider same-sex attractions and diversity in sexual orientation, gender identity, or gender expression to be mental disorders.

10. "Conversion therapy" (CT), or reparative therapy, refers to psychological interventions that seek to change the treatment recipient's sexual orientation from gay, lesbian, or bisexual to

[2] Sexual orientation identity is distinct from sexual orientation. It refers to an individual self-identification as heterosexual, gay, lesbian, or bisexual.

[3] Gender identity is also distinct from gender expression. Gender expression refers to how a person expresses their internal sense of identity, including through their demeanor, dress and behavior. Many people are gender-nonconforming. This means that their gender expression does not conform to traditional gender roles or norms. Being gender nonconforming does not mean that a person is transgender, lesbian, gay, or bisexual. "Gender dysphoria" is the significant distress a person experiences from the mismatch between the sex they identify as and the sex they were assigned at birth.

heterosexual, or to change a transgender or gender non-conforming identities to match the assigned sex at birth or reduce gender non-conforming behaviors and demeanors.

11. CT includes efforts that claim to reduce attractions, feelings and behaviors associated with same-sex sexual orientations. In children and adolescents, CT includes attempts to change a child's or adolescent's sexual orientation or efforts to prevent the development of a same-sex sexual orientation and identity in adolescence and adulthood. CT also includes efforts to change gender expression (e.g., demeanor, actions, and dress associated with gender roles) and to suppress gender nonconforming behaviors in order to prevent or change gender nonconforming identities or transgender identities. Efforts to change gender expression in children and adolescents are also applied in an effort to prevent a child from growing up to be lesbian, gay, bisexual, or transgender.

12. CT interventions are varied. Currently, most are non-aversive talk therapies that include psychoanalytic techniques, cognitive and behavioral therapies, medical approaches, group therapy, peer groups or family therapy, and can include role plays, and religious and spiritual counseling. CT can also include aversive techniques.

13. Survey data estimates that about 350,000 adults in the United States received CT when they were adolescents and about 20,000 youth (ages 13-17) will receive CT from a licensed health care professional before they reach the age of 18.[4]

14. CT is based on outdated, unscientific beliefs and false stereotypes about the causes and nature of sexual orientation and gender identity. These pernicious stereotypes inaccurately claim that lesbian, bisexual, gay, and transgender (LGBT) individuals are incapable of leading productive lives and engaging in stable sexual and family relationships. Many conversion therapists

[4] Mallory, C., Brown, C.N.T., & Conron, K.J. (2018).

claim, for example, that being gay, lesbian or bisexual, or transgender, is caused by problematic dynamics between parents and children, child abuse, or sexual abuse. These ideas have been thoroughly discredited through decades of scientific research. They are inconsistent with an evidence-based understanding of sexual orientation and gender identity.[5]

II. Conversion therapy treatment interventions are harmful and ineffective.

A. Core Aspects of Healthy Child and Adolescent Development.

15. In order to fully understand the profound harm experienced by children and adolescents subjected to CT, it is important first to explain some of the key developmental tasks related to sexual orientation and gender identity for all children. As will be further explained below, CT undermines and counteracts the building blocks of a healthy childhood, adolescence, and adulthood.

16. The development of gender identity and sexual orientation are universal processes that take place early in childhood. They are part of each phase of a child's cognitive, emotional and physical development. As a child matures, their cognitive ability and identity becomes more sophisticated. Family and cultural messages about difference and identity are more evident and understood and peer acceptance becomes more important. Sexual orientation development is heightened in adolescence during puberty when youth develop deeper friendships and intimate relationships, focus on a future occupation, achieve greater emotional independence from their parents, and develop their own values. Gender identity diversity and nonconforming behaviors start in early childhood, but with puberty, gender diverse adolescents are faced with an increased awareness of the discordance between their gender identity and physical body, potentially leading to heightened distress.

[5] See, for example, one of the earlier studies finding that these stereotypes are inaccurate, Bell, AP, Weinberg, WS & Hammersmith, SK (1981).

17. A fundamental basis of human development is the establishment of trusting human relationships early in life; children depend on families and communities for love, protection, and safety. Most children thrive when provided with love and support, and know that others are committed to their growth to adulthood. It is important that young people have spaces in which they feel safe enough to explore core aspects of their identities.

18. However, children are vulnerable to the disapproval and rejection of others. They learn from an early age whether their feelings match cultural expectations. Sadly, even after decades of progress, sexual orientation and gender diversity are stigmatized—devalued, denigrated and seen as less-than. Positive images of gender and sexual orientation diversity are lacking, and children and adolescents are often not exposed to positive lesbian, gay, bisexual, transgender (LGBT) role models. It is a double burden to grow up without positive role models and to protect one's self-esteem from these negative stereotypes.

19. At each stage of developmental change, lesbian, gay, bisexual, transgender and questioning (LGBTQ) children often feel isolated and alone. Many LGBTQ children and adolescents must navigate the awareness and acceptance of their socially marginalized sexual orientation or gender identity without adequate information and support.

20. Adolescents face particular challenges. The teen years are a crucial time to explore, accept, and integrate sexual orientation and a mature gender identity into their developing lives. Key questions arise: How will I fit in? Will people reject me? Will I find a partner or create a family? Do I have a future being my true self? For those who experience their LGBT orientation and identity as "less-than," bad or inadequate, these questions are even harder. Such individuals will likely develop chronic feelings of shame and/or guilt. Many will avoid or postpone key tasks

of identity acceptance, integration, and family formation because the stress is so overwhelming.[6] This is harmful as delays in adult milestones have long-term emotional, educational and employment effects resulting in a greater chance of emotional distress and lower levels of educational and vocational achievement.

21. Along with the isolation caused by disapproval and the shame imposed by the larger culture, many children and adolescents are exposed to actual discrimination and aggression, from disrespect to bullying to even violence. Discrimination, cultural stigma, and exposure to or threat of violence create "minority stress," a phenomenon also experienced by other stigmatized minorities.

22. Minority stress is linked to poor mental and physical health, particularly psychological distress.[7] In fact, recent research on adolescents indicates that LGBT adolescents are at a greater risk of mental distress than their heterosexual peers because of the stress of anti-LGBT prejudice and discrimination.[8]

23. Importantly, these increased risks of emotional distress are not a function of the sexual orientation or gender identity of LGBT children. Rather, these negative mental health outcomes stem from the harmful impact of prejudice, discrimination, rejection, harassment, and violence directed at those who are LGBTQ or are perceived to be LGBTQ.[9] Children and adolescents experience these negative influences more profoundly than adults due to their increased emotional vulnerability and less developed capacity to cope effectively with the harm of discrimination. For example, one study conducted before the Supreme Court ruled that all states must permit same-

6 Russell, S. & Fish, J. (2016); see generally Diplacido (1998).
7 Hatzenbuehler, M.L. & Pachankis, J.E. (2016).
8 Ibid; Russell & Fish (2016).
9 Ibid.

sex couples to marry found that adolescents growing up in states that barred same-sex couples from marriage have higher rates of suicide attempts than adolescents in states with marriage for same-sex couples.[10]

24. CT worsens minority stress by reinforcing negative societal stereotypes and conveying inaccurate information; this increases depression, self-hatred, blame, and hopelessness.[11] Rather than debunking these stereotypes, and reducing the shame and stigma faced by these children and adolescents, CT interventions undermine their self-esteem, identity acceptance and integration by telling them that their deeply-felt identity and ability to love are "wrong" and "bad."[12] Similarly, for young children who are struggling with gender issues, being pressured to change their gender expression or to conform to gender stereotypes can worsen their distress because it undermines their sense of self and creates deep-seated shame.[13]

25. Further, CT poses an additional significant risk of harm because it does not provide children and adolescents with the benefits of sound psychotherapy to bolster their mental health. In any psychotherapeutic intervention, children and youth need support, reassurance of their self-worth, and a sense that a professional is committed to helping them with openness and understanding of their conflicts and fears. CT does just the opposite. Individuals subjected to this negative therapeutic experience in CT will be less likely to seek out psychotherapy in the future, an impediment that creates an additional risk to their mental health.[14]

26. CT also interferes with a healthy parent-child relationship. According to a decade of family research, CT gives parents false and harmful information. It encourages parents to interact

10 Raifman, J, Moscoe, E., Austin, S.B., & McConnell M. (2017).
11 American Psychological Association (2009a); Nadal, K. L., Skolnik, A., & Wong, Y. (2012).
12 Ryan, C., Toomey, R., Diaz, R.. & Russell, S. T. (2018); Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009).
13 Rosenberg, M., & Jellinek, M. S. (2002).
14 Craig, S. L., Austin, A., Rashidi, M., & Adams, M. (2017).

with their children in damaging ways, which can lead to children feeling even more rejected by their family and even more alone. CT fails at the therapeutic goal of assisting families in providing a supportive environment for children and reducing behaviors that can harm children. To the contrary, CT teaches parents to invalidate a child's deeply felt feelings about who they are which leads to dangerous behaviors, such as suicidal ideation and suicide attempts.[15]

B. The Medical and Scientific Research Demonstrates that Sexual Orientation and Gender Identity Cannot be Changed.

27. All existing valid empirical research data shows that sexual orientation change efforts are ineffective. There is no existing scientifically-valid research that shows that sexual orientation in children, adolescents or adults can be changed by psychological interventions, or that CT can reduce same-sex sexual attractions or increase heterosexual attractions. Nor is there is any valid scientific evidence of lasting change in sexual behaviors (i.e, a decrease in same-sex behaviors or increase in heterosexual behaviors). The APA Report thoroughly analyzed decades of research and concluded: "…the participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that could be empirically validated."[16] Any efficacy claims made by providers of CT are unsubstantiated.

28. Claims that CT can change gender identity are not scientifically supported as either effective or therapeutic practices.[17] CT that focuses on changing gender identity and expression is sometimes used to try to change sexual orientation. There is no validity to this approach and these practices are perceived by participants as ineffective.[18]

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15 Ryan, C., et al. (2009).
16 See American Psychological Association (2009a) Exhibit B (p.2).
17 Rosenberg & Jelinek (2002); Substance Abuse and Mental Health Services Administration (2015).
18 Bradshaw et al. (2015); American Psychological Association (2009a).

29. Research to assess the perceptions of CT participants conducted since the APA Report supports these conclusions of ineffectiveness.[19] This research includes three different studies of members of the Church of Latter-Day Saints (persons highly motivated to change), including one study of over 1000 persons who experienced interventions to change sexual orientation. The study concluded that CT failed to change participants' self-reported sexual orientation.

30. As a result of the body of evidence, CT is rejected as a treatment by all the major mental health, counseling, and health organizations in the United States, including those for children, as well as many international health associations and government entities. For example, the American Psychiatric Association reiterated its opposition to sexual orientation change efforts in November 2018 and explicitly cited the dangers associated with SOCE originally published in 2013:

> "The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed."

31. Other medical and mental health associations worldwide have either explicitly rejected CT for LGBTQ individuals or written guidelines for children, adolescents, and adults excluding such approaches. The American Psychological Association, American Psychiatric Association, American Medical Association, American Academy of Family Physicians, American Academy of Child and Adolescent Psychiatry, American Counseling Association, American Academy of Pediatrics, American Psychoanalytic Association, Australian Psychological Society, British Psy-

[19] Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Hyde, D. C., & Crowell, K. A. (2014); Flentje, A., Heck, N. C., & Cochran, B. N. (2014); Maccio, E.M. (2011).

chological Association, Endocrine Society, National Association of Social Workers, Psychological Society of Ireland, Psychological Society of South Africa, and the World Professional Association for Transgender Health have all published recommendations, resolutions or guidelines.

C. The Medical and Scientific Research Demonstrates that Conversion Therapy Poses A Substantial and Unacceptable Risk of Severe and Lasting Harm for LGBTQ Children and Adolescents.

32. Research from authoritative scientific studies concludes that CT poses significant risks of harm. Past studies (from 1960-2007) described in the 2009 APA Report indicate that the risks of harm to adults from both talk therapies that were non-aversive, as well as aversive approaches that are less common now, include feelings of distress, anxiety, depression, increased suicidal ideation and suicide attempts, increase in substance abuse, self-blame, guilt, and loss of hope, among other negative feelings, as well as disillusionment with religious faith, and harm to family relationships.[20] More recent research on adults who participated in CT since 2007 supports the reports of harm documented in the 2009 APA Report. One study found that 37% of all participants reported moderate and significant harms including those found in the APA Report, such as increased risk of suicidality, depression, self-blame, and disillusionment with faith. This is a high rate of harm relative to alternatives. In this same study, those who received therapy that encouraged identity exploration found such approaches beneficial and not harmful as compared to those in CT.[21]

33. Research shows that CT also poses a significant risk of harm to gender diverse people, including individuals who have a gender identity different from their sex assigned at birth. The

[20] Currently, aversive techniques often use unpleasant stimuli: negative smells, snap or a rubber band. Non-aversive approaches do not use these techniques. In the past aversive interventions included electric shock, emticis (vomit-inducing) and other painful physical interventions. These later techniques are rejected in modern practice.

[21] Bradshaw, K., Dehlin, J.P., Crowell, K.A., Galliher, R.V. & Bradshaw, W.S. (2015).

available research shows that CT forces gender conformity and reinforces stigma and discrimination toward gender diverse people. These practices are associated with poor psychosocial outcomes, such as heightened psychological distress, compromised overall wellbeing, and health disparities.[22]

34. Families often seek out CT when distressed about their child's sexual orientation and gender identity. In particular, gender nonconforming youth are more likely to be taken by their parents to receive CT to change their gender expression and identity.[23] As noted above, unlike other therapies that help parents support their children's unique developmental tasks, CT often encourages parents to engage in coercive, rejecting, and critical behaviors, based on false claims that these behaviors can change or influence a child's gender identity or sexual orientation. The rejection of an adolescent's gender identity and expression is harmful as it is associated with poorer emotional, social and vocational outcomes, and gender identity change efforts are clear examples of rejection.[24]

35. The risks posed by CT are demonstrably dangerous for adolescents. Research, published since the APA Report in 2009, on young adults who experienced such efforts in adolescence shows that these types of practices pose very serious psychological risks. Recent research published in 2018 on young adults who reported that they had been subjected to CT in adolescence revealed serious harms. These individuals were *3 times* more likely to have attempted suicide and to have had suicidal ideation (thoughts of suicide) than LGBT adolescents who are not subjected to CT. Adolescents who had been subjected to CT reported being seriously depressed *3.5 times* more often than those who had not. Beyond the negative short-term mental health effects,

[22] Substance Abuse and Mental Health Services Administration (2015); American Academy of Child and Adolescent Psychiatry (2018); Society of Adolescent Medicine (2013).
[23] Ryan, C., et al. (2018).
[24] Ibid.

participants also experienced negative long-term effects such as lowered life satisfaction, less social support, lower socioeconomic status, and other serious difficulties in their young adulthood that could impact them over the long term.[25] Another 2009 study showed that CT applied during adolescence is one of several types of rejecting parental behaviors that increase the rates of depression, suicidal ideation and suicide attempts in young adults. In fact, those who have had these rejecting experiences are twice as likely to experience depression, suicidal ideation, and suicide attempts as those LGBT individuals who have not experienced rejecting behaviors and the rates of depression, suicidal ideation and suicide attempts increase as the amount of rejection increases.[26]

36. The risk of harm to children and adolescents from CT is heightened by additional considerations. Therapeutic interventions for children and adolescents must account for their physical, emotional and cognitive immaturity relative to adults. [27] It is therefore reasonable to be particularly concerned about the likelihood of serious risks to children where there is research demonstrating that CT also poses a serious risk of harm to adults. Children and adolescents are particularly in need of appropriate therapeutic interventions given their stage of psychological development. Young people subjected to CT are delaying or being denied effective treatment for the psychological distress they are experiencing, thus potentially increasing the risk of life-threatening conditions such as suicidal ideation and suicide attempts. Indeed, for adolescents who are particularly vulnerable to hopelessness, being told you can change your sexual orientation or gender identity, and then discovering that such assurances lead to failure, only increases despair and hopelessness.

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25 Ibid.

26 Ryan, C., et al. (2009).

27 See Special Protections for Children as Research Subjects, Department of Health and Human Services https://www.hhs.gov/ohrp/regulations-and-policy/guidance/special-protections-for-children/index.html.

37. Due to these harms, sexual orientation and gender identity change efforts for children and adolescents are considered invalid. The US Substance Abuse and Mental Health Services of the Department of Health and Human Services has rejected CT for these populations and stated about gender identity change efforts:

> "Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes."[28]

D. Appropriate Interventions for Children and Adolescents

38. There are safe and effective psychotherapies for children, youth, and families confronting these issues. The standard of care for this population stresses acceptance of the child as a whole person and includes affirming the validity of their identity conflicts, including those rooted in religious belief. Appropriate therapy includes providing safety and protection from bullying, discrimination and harassment, and openness and commitment to their welfare without having a specific sexual orientation or gender identity outcome.[29] This requires a careful assessment of the child and their concerns, including identifying if there is distress and its origins, the gender identity or sexual orientation issues, the child's cognitive and emotional capacities in a developmental framework, and any mental health concerns.

39. Health professionals focus on reducing distress and increasing the child's capacity to cope with stigma or cultural invalidation, including LGBT stigma. The mental health provider assists the child in developmentally appropriate exploration of sexual orientation and gender

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[28] Substance Abuse and Mental Health Services Administration (2015).

[29] Those organizations with relevant treatment guidelines include American Academy of Child & Adolescent Psychiatry; American Academy of Pediatrics, American Psychological Association, American Counseling Association, Australian Psychological Association, New Zealand Psychological Association, Society for Adolescent Medicine, and the World Professional Association for Transgender Health.

identity. Under both practice standards and ethical guidelines, the emergence of a minor's unique identity should be allowed without interference from the therapist, such as a pre-set or imposed sexual orientation or gender identity outcome.[30] Such affirmative approaches have been empirically validated in the reduction of the depression, anxiety and suicidal ideation that harm those who are LGBTQ or are conflicted.[31] Therapies can similarly help families understand their child's conflicts and concerns and provide tools to communicate about these challenging issues without damage to the child's mental health. A child's distress can be reduced even when parents' do not approve or accept their child's sexual orientation or gender diversity.[32]

E. There are No Scientific or Ethical Justifications for the Discredited Practice of Conversion Therapy.

40. CT proponents may claim that their treatments are effective, but these claims lack a sound scientific basis. Conversion therapists have utterly failed to carry out such types of research.[33] The APA Report examined CT research for its ability to validate its claims and a few key points will be discussed below.

41. The APA Report found that the pro-CT studies rarely made any effort to define what constitutes "sexual orientation" and confused sexual orientation with sexual orientation identity, gender identity, and behavior. One example is that CT does not assess bisexuality. Without an assessment model that acknowledges bisexuality (a capacity for different-sex and same-sex sexual orientation), bisexual individuals could be counted among those whose orientation had

30 American Psychological Association (2009a); Substance Abuse and Mental Health Services Administration (2015).

31 Among the examples of randomized trials, a hallmark of the highest quality research, is Pachankis, J.E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015); Burton, C.L., Wong, K., Pachankis, & Pachankis, J. (2017).

32 Ryan, C., Russell, S. T., Huebner, D. M., Diaz, R., & Sanchez, J. (2010); Substance Abuse and Mental Health Services Administration (2014).

33 American Psychological Association (2009a).

"changed" when it had not, as opposed to purported change in those who are exclusively oriented to the same sex. More recent studies include all sexual orientations and gender identities and found that CT was ineffective and harmful.[34]

42. The APA Report found that the subjects in studies purporting to validate CT were often referred by CT practitioners or were referred by "ex-gay" organizations. This "sampling bias" runs counter to the scientific standard of trying to find a broad sample of participants, and renders the results unreliable. When working with small communities or faith groups, participants should be randomly selected from as many potential participants to avoid bias. Selecting only participants who have been "chosen" or that are selected from a specific program risks selecting only those who are biased in favor of a particular result, or avoiding those who have been harmed or feel the experience is a failure.

43. As to claims of causality, the APA Report found that pro-CT studies on adults relied exclusively on self-reports of change, and typically retrospectively. For the adults in these studies, many of whom hold, and are part of communities with strong views about the undesirability of being gay, it is likely that they overstated their perceived success in changing their orientation. Many people will also find that their memory of specific events in the past has faded or is shaped by the outcome they wish had occurred. Nor do these studies offer any follow up about the longer-term results of such treatment.

44. There are many issues with respect to data analysis in reports of those favoring CT. For example, pro-CT studies often ignore the extremely high dropout rates. This is significant because for those individuals, the treatment could well have been ineffective or harmful.[35]

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[34] Bradshaw et al. (2015); Dehlin et al. (2014); Ryan et al. (2018).

[35] There are examples of conversion therapy research which did not set out to study harms, but participants reported experiencing significant harms through these approaches. This was discussed in the APA Report as well as more

45. The APA Report identified research showing that some individuals, in addition to reporting no changes in sexual orientation and gender identity, perceived they had been helped by CT with regard to reducing isolation, loneliness and lack of social support. This is a not an adequate assessment of efficacy as CT did not fulfill its claims of change. Many types of social support, fellowship, and therapy can provide such comfort. As the APA Report noted, "the benefits reported by participants in [conversion therapy] can be gained through approaches that do not attempt to change sexual orientation," or through standard mental health or support groups.[36]

46. Conversion therapists sometimes claim that their practices assist those whose sexual orientations have, in their view, been caused by sexual abuse. But there is no credible link between a same-sex sexual orientation and sexual abuse. The American Academy of Pediatrics has concluded that "[T]here is no scientific evidence that abnormal parenting, sexual abuse, or other adverse life events influence[s] sexual orientation."[37] In any event, CT is not a scientifically valid treatment for sexual abuse. Evidence-based treatments for sexual abuse, and other abuse and trauma, focus on establishing safety and support and assisting survivors in managing post-traumatic stress and other mental health distress, reducing shame and self-blame, and resolving traumatic memories. Changing sexual orientation is not part of these treatments and can increase shame and self-blame. The disclosure of sexual abuse in children and adolescents is a crisis and

recent research that documented harms such as increased emotional distress, depression, health risks, substance use, and suicidality. American Psychological Association, (2009a); Bradshaw et al. (2015); Ryan et al. (2018)

[36] American Psychological Association (2009a), Bradshaw et al. (2015)

[37] Frankowsi, B.L., & Comm. On Adolescence (2004). This report also states that sexual orientation is usually established during early childhood.

the overriding need is for emotional support. Comprehensive explanation guidelines for the treatment of sexual abuse and post-traumatic stress exclude CT and focus on sexual orientation and gender identity neutral approaches.[38]

47. Other attempted justifications for CT include the perverse use of positive values in therapy such as "self-determination" or "informed consent." These claims must be examined critically since it is clear that pursuit of CT is driven by societal and internalized stigma.[39]

48. While any competent, ethical therapist respects a client's right to self-determination, therapists cannot offer a "consumer choice" model of treatments because therapists are bound by medical and ethical guidelines to consider the efficacy of treatment and potential for harm. Ethically, therapists cannot apply treatments that pose a significant risk of harm even if requested.[40] Similarly, psychologists are bound to respect and protect civil and human rights, and ensure that their treatments provide benefit, as well as avoid the risk of harm.[41]

49. Informed consent does not assist the case of CT practitioners. Informed consent requires that the client be provided accurate information on the condition and potential benefits and harms of intervention. Yet, CT providers convey false, unscientific and discredited information, such as that homosexuality is a disorder or a symptom of a disorder, that homosexuality does not exist, or that gay and transgender people's lives are unhappy and unfulfilling.[42] Informed consent also requires a clear understanding of benefits and harms of any intervention. A treatment that

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[38] Saunders, B.E., Berliner, L., & Hanson, R.F. (Eds.). (2003*)*; Forbes, D. et al. (2010); American Psychiatric Association (2010).

[39] American Psychological Association (2009a). Conversion therapy has declined as stigma towards this population recedes, as with the removal of "homosexuality" as a psychiatric disorder from the Diagnostic and Statistical Manual in 1973 and legal changes ending the criminalization of same-sex sexual intimacy and allowing same sex couples to marry. See Chapters 1 & 2 APA Report (2009a).

[40] American Psychiatric Association (2013).

[41] American Psychological Association (2016).

[42] Schroeder, M, & Shidlo, A. (2002).

poses a significant risk of harm without unique benefits fails to meet minimal standards of informed consent because a treatment can only be offered if it provides benefits. Ethically, even if a client asks, mental health and health practitioners must avoid the risk of potential harm and provide treatment that benefits the client. There are a variety of alternative treatment options for this population outlined in professional guidelines.

50. In addition, informed consent can only be provided when the therapy is voluntary and pursued without undue influence, such that the client should ultimately be able to *refuse* or accept treatment. Children and adolescents cannot legally consent to treatment due to their minority, and in any event, may be taken to therapy regardless of their wishes, and lack the opportunity to refuse such treatment.

51. Finally, informed consent requires the person to be competent to understand the short term and long-term consequences of the treatment. It is very unlikely that a child or adolescent can foresee the potential consequences or harms of these treatments. A minor's ability to understand long-term consequences of denying or changing their sexual orientation can be limited when they may not have reached puberty, or experienced sexual arousal, let alone fallen in love, or experienced the type of emotional intensity found in relationships. Likewise, gender identity is an aspect of self that has profound social and personal elements across one's lifespan; children and adolescents may not understand the emotional impact of change efforts.

F. Conclusion

52. The proposed state ban on CT is consistent with the psychological research, professional guidelines, and recommendations for the treatment of children and adolescents with concerns regarding sexual orientation and gender identity. This legislation protects minors from a discredited and harmful practice.

Glossary

Gender dysphoria: Psychological distress due to the incongruence between one's physical body and gender identity.

Gender expression: The expression of gender identity through dress, clothing, body movement, etc. Young children express their gender through preferences and choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

Gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act based on their physical sex labeled at birth.

Gender identity: A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

LGBT: Lesbian, gay, bisexual, and transgender

LGBTQ: Lesbian, gay, bisexual, transgender, and questioning

Sex assigned at birth: The sex designation given to an individual at birth.

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, lesbian and gay (homosexual) bisexual and includes components of attraction, behavior, and identity. Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy. Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active.

Sexual orientation identity: How someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

Transgender: A person who feels that their gender identity does not match their physical body and differs from the gender that others observed and gave them at birth (assigned or birth gender).

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