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SERIOUS HARMFUL IMPLICATIONS OF THERAPY BAN BILLS

Science and Research Council:
International Federation for Therapeutic and Counselling Choice

Proposals to ban therapy for those who wish to explore options to their sexual or gender feelings and behaviors will have seriously harmful implications. We present evidence here.

I. NEGATIVE IMPACTS OF BANS ON CLIENTS AND THERAPISTS

1. **"Conversion therapy" is an imposed, pejorative term.** It confuses unethical practices (aversion therapies and coercive methods) with standard, voluntary psychotherapeutic and counselling approaches.

2. **Opponents to "conversion therapy" appear to equate all therapy that is open to a client's goal of change with harmful "conversion" therapy utilizing aversive or coercive methods.** The characterization of all change allowing therapy as harmful stigmatizes and puts at risk ethical therapy that uses mainstream therapy methods and has been demonstrated to be helpful and effective for many.[1,2]

3. **"Conversion therapy" ban bills that make exceptions to allow help to change certain behaviors, such as behaviors that are harmful or illegal, but not sexual *attractions* or gender identity or expression *feelings or desires* to engage in those behaviors will prohibit much-needed conventional therapy** for individuals with unwanted same-sex attraction or behavior or unwanted gender identity feelings or behavior. This is because it is next to impossible for a therapist to completely separate therapy that could lead to a change in a person's same-sex attraction feelings or confused identity feelings, from therapy for related behavior, as attractions or feelings and behaviors are inextricably linked.

4. Some bans do not allow help to change any same-sex or gender behaviors or feelings. If a therapy ban does not permit an exception to allow help to change sexual or gender behavior that is dangerous or illegal, that ban is dangerous. Therapists ordinarily help people change dangerous or illegal behaviors. If a therapy ban permits an exception for help to change dangerous or illegal sexual or gender behavior, it should allow everyone the right to change unwanted sexual or gender behavior for whatever reason they wish. The state should not discriminate. Therapy that helps to diminish unwanted behaviors generally proceeds by helping to diminish the desire or attraction to engage in such behaviors. It would be next to impossible to change behaviors, be they dangerous, illegal, or any other that a client wishes to change, if therapists must not help clients change feelings of sexual or emotional attraction to engage in those unwanted behaviors. If clients are allowed help to change attraction feelings when necessary to change dangerous or illegal behaviors, they should be allowed help to change any unwanted feelings of attraction, regardless of whether they are tied to unwanted behaviors, without discrimination.

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5**. It will also be next to impossible for any government to regulate standard therapy and counselling approaches in a way that would ensure that no changes** or diminishing in same-sex attraction feelings, behaviors or confused identity feelings occur. These changes can occur throughout the life span in response to life experiences, and there is no way to insure there will be no life experiences in therapy or that therapy will not be a life experience in itself. What would it mean to conduct therapy that is not life experience? Life experiences that lead to change in sexual or gender feelings or behaviors may include relationship experiences. Therapists help people with relationship experiences, and therapy itself is a client-therapist relationship that may help bring about change. Therapists ordinarily help clients with goals to change feelings, behaviors, self-perceptions, relationships, and life experiences.

6. Therapy bans generally require neutrality in place of change therapy for a client's choices of sexual or gender feelings, behaviors, or identities. **It will be next to impossible for the government to regulate therapy "neutrality," nor is neutrality always an effective therapy for unwanted same-sex feelings or behaviors or gender identity confusion.** How can private conversations between clients and their therapists be regulated fairly? This will create a chilling effect on therapy as therapists will fear punishment if they delve into these areas at all. Who will decide what constitutes change therapy and what does not, and how will it be policed?

7**. The proposed therapy ban therefore is a violation of the free speech rights of therapists.**

8**. The most serious cases of *unwanted* same sex sexuality or gender confusion require professional therapy.** If a ban becomes law, adults and children who need therapy will be hard-pressed to find a therapist willing to take the risk of being accused of providing change allowing therapy.

9. **The common argument that same-sex attraction and behavior is not an "illness" or "disorder," and therefore change allowing therapy and counselling should be prohibited is invalid.** There are numerous examples of professionally approved targets of treatment that are not considered to be illnesses. These include relationship distress, bereavement, career dissatisfaction, and unplanned pregnancy. In addition, the fact is that clients pursue psychological care for many difficulties due to deeply held religious and moral beliefs (for example, that divorce or abortion is wrong) and may experience significant emotional distress in addressing these issues.

10. **Individuals often seek to align their LGBTQ behavior or feelings with other goals such as these:** (1) They identified as LGBTQ and had LGBTQ experiences but did not find them fulfilling. They want to live the way that brings them fulfillment. (2) They feel their LGBTQ behavior was caused by trauma. They want the right to explore this freely and heal – which may, as a by-product, lead to a diminishing their same-sex attraction and gender confusion. (3) They want to live according to their beliefs or ethics that should be respected. (4) They aspire to procreate children with a future spouse and raise their children together. Those who seek therapy, not the state, should choose who gets therapy and for what reasons. **We urge the state not to support discrimination over who can get help and what help they can get.**

11**. Therapy bans for contemporary change allowing therapies diminish hope for individuals who struggle with unwanted attractions or identities because of their religious beliefs that should be respected**, including people from all the major faith groups.

12**. It is premature to dictate what current therapies are effective or not since there is widespread disagreement on such in the scientific literature.** The scientific process, not legal fiat or activist lobbies in professional guilds, should be allowed to resolve scientific questions.

II. NOT "BORN THAT WAY" – RESEARCH FINDINGS ON SEXUAL ORIENTATION

1. **Research has established that same-sex attraction and behavior are traits that develop from a mixture of genetic and environmental influences,**[3,4] **but mostly**[5,6] **from individuals' experiences in their psychological, social, cultural, and possibly biological environment, and that these traits may shift or change through life experience**[7,, 89]**–** like many other complex human traits, behaviors, or unwanted tendencies, psychotherapists help people diminish or change every day, using evidence-based methods and well-established practices.
There is no reason that therapy that is open to change in unwanted sexual or gender feelings or behaviors should be any more dangerous or less effective than therapy to change other unwanted traits.

2. The largest gene study (August 2019) has stated: "Behavioral traits, like sexual behavior and orientation, are **only partially genetic** in nature….they are also **shaped in large part by a person's environment and life experiences**…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 behavior and orientation."[10]

3. Reputable research has established that **LGB adolescents**[11,12] **and adults,**[13,,1415] **commonly experience shifts or changes in their sexual orientation through life experience, and these shifts are mostly toward or to heterosexual.** Therapy is **life experience**.

III. SCIENCE REGARDING SAFETY OF CHANGE ALLOWING THERAPY

1. **Aversive/behavioristic methods have not been used by therapists in 40-50 years.** This is the admission of the APA's task force report (2009)[16] and even of Utah law professor, Clifford Rosky (2019), who has written therapy bans in the US.[17]

2. **Members of our professional organizations who are open to a client's goal of change in sexuality or gender are guided by ethical guidelines.**[18,19] **They work to reduce shame which helps allow for change to occur naturally**. They do not guarantee therapy outcomes. Therapy often provides many benefits, whether changes in sexuality or gender are partial, full, or none. Even partial change can change a life. It is important to note that change is usually not a categorical "change", but takes place on a continuum, as is the case for nearly every other psychological and behavioral condition for which people seek professional care.

3. **The American Psychological Association task force on therapy (2009) concluded there is no research meeting scientific standards that shows contemporary change allowing therapy is harmful, ineffective, or leads to suicide for adults or minors.** It said scientific research that did not meet its standards reported some adults changed same-sex attraction and behavior through therapy and some adults felt harmed. It then used only the latter, anyway, as anecdotal, not scientific, evidence and based its recommendations on that.[20] The task force was biased. It cited no research (because none exists) showing affirmative therapy is better. It also did *not* declare change allowing therapy unethical.[21]

4. **A US federal judge's decision (2019) regarding a therapy ban that only applied to minors noted the many ways that expert witnesses opposing "conversion therapy" for minors admitted that there is no research on therapy with minors** for unwanted same-sex attraction or behavior or for gender nonconforming identity that meets scientific standards**.**[22] **There is no more recent research that changes this status.**

5. **Voluntary psychotherapy using evidence-based interventions and well-established practices treats underlying psychodynamic and trauma factors** that clients feel led to their unwanted same-sex attraction or behavior. Change may result as a by-product. This much needed therapy should not be banned. Adults and minors should not be shamed for their reasonable and warranted request to have this therapy. Is it more compassionate to offer treatment that is open to a client's desire for this change, or to affirm unwanted feelings or behaviors forced on victims by childhood trauma and just teach coping methods?

6. **One of the most comprehensive reviews ever conducted on a century of research,** including studies published by American Psychological Association (APA) members in APA peer-reviewed journals, provides evidence that some people changed their sexual attraction and behavior when accompanied by professional therapy assistance.[23,24]

7. **We work together with therapists and counsellors around the world who support this therapy** that may lead to these changes.[25] Claims to the contrary notwithstanding, there is not a professional consensus in opposition to such therapy.

8. There is no scientific basis on which to censor change-allowing therapy, and misrepresentations to the contrary are harmful. Some who diminished or changed their sexual or gender feelings or behaviors 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 try to change through therapy.

IV. RESEARCH FINDINGS ON SUCIDE

1. The most recent Ryan study (2018),[26] which has been used to claim change allowing therapy is harmful and contributes to suicide, was conducted by an LGBT advocacy organization and had the following serious flaws:

- This small study near San Francisco, purporting to show harm from "conversion therapy," looked at only parent-initiated efforts, by surveying adults who currently frequent LGBT bars, and asked about their adolescent experiences with regard to "conversion therapy." **By research design, the study excluded any youth who may have changed through therapy, since they recruited participants only from LGBT-supportive venues. The survey did not study client-initiated therapy at all. It has nothing to say about it.**

- **There was no control group, and the study relied on self-reports** of adults in the LGBT community who may have had a political interest in portraying change allowing therapy as harmful.

- **The definition for what constituted "conversion therapy" was vague**, nor was it clear if any such therapy was conducted by a licensed therapist using non-abusive, non-aversive, non-coercive, contemporary, evidence-based methods and well-established practices.

- **The report identified parents and clergy as the most egregious violators of "conversion therapy,"** because they promote various religious values in regard to sexual behavior and gender identity.

- **Research does not, however, support the view that traditional faiths cause mental health disparities for people who identify as LGBTQ.** Findings show those who follow their traditional faiths that reject same-sex relationships are no less happy, mentally healthy, satisfied with life, and flourishing than those of faiths that accept same-sex relationships or those of no faith. [27, 28, 29, , 3031]

2. Many potential risk factors for LGBTQ youth suicide have been identified, including depression, sexual promiscuity, alcohol and drug use, and more. For example, the CDC Youth Risk Behavior Surveillance—U.S. 2017[32] found that LGBTQ youth not only had the highest rates of suicide attempts or thoughts, but they also experienced higher rates of behaviors that are associated with higher suicide rates as follows:

- prevalence of current alcohol, marijuana, cocaine, heroine, or meth use
- sexual intercourse before age 13
- sexual intercourse with four or more persons
- forced to have sexual intercourse
- experienced sexual dating violence

Since suicide risk factors have been found to be much higher for LGBTQ-identifying youth *irrespective of therapy,* one cannot simply presume therapy is to blame.

3. Genes also may contribute to suicidality in LGB youth. The largest gene study reported, "We found several personality traits (loneliness and openness to experience), risky behaviors

(smoking and cannabis use) and mental health disorders, but not physical traits, to be significantly genetically correlated with same-sex sexual behavior. **We found in both sexes that same-sex sexual behavior was positively genetically correlated with several psychiatric or mental health traits,"** for example, depression and schizophrenia in both sexes and bipolar disorder in females[33] (bold added).

4. Some clients report their **depression[34] or suicidal thoughts[35] actually subsided or diminished because of the change allowing therapy they received**.

5. While about 18 states in the U.S. have legislated "conversion therapy" bans over the past seven years, and about as many or more states have rejected these bans or allowed them to die, **there is no evidence whatsoever that the rate of teen suicide in states that have bans has been impacted in any positive way.**

V. FURTHER RESEARCH ON SAME-SEX ATTRACTION

1. The US APA task force report (2009), recommending LGBT affirming therapy and discouraging any kind of change allowing therapy, claimed its recommendations were based on what the task force characterized as "key" scientific facts, including findings that (1) sexual orientation does not change through life events, and (2) same-sex orientation is not caused by trauma or family dysfunction.[36] **But the task force failed to mention that the studies it relied on did not meet the APA task force's own scientific standards.**[37] If those presumed scientific facts 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 is the exact claim being made by LGBT activist groups pushing for a therapy ban now.

2. However, five years after the APA's task force report made these claims to discourage any change allowing therapy, the ***APA Handbook of Sexuality and Psychology*** **(2014),** which the APA declared "authoritative,"[38] **contradicted these claims** wherein it actually recognized:

- **Sexual attraction, romantic partnerships, behavior, and identity all commonly change for adolescents and adults.** "…research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time." "Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation." "Over the course of life, individuals experience the following: (a) changes or fluctuations in sexual attractions, behaviors, and romantic partnerships…."[39]

- **Childhood sexual abuse has "associative and potentially causal links" to having same-sex partners for some,** based on research that includes a 30 year study of documented cases of childhood sexual abuse.[40, 41] Many studies have found an

association between childhood sexual abuse and same-sex sexuality. [42,43,44] Some theorists have hypothesized that LGBTQ children only suffer abuse at the hands of parents, because parents see gender nonconforming behavior in these children and want to eradicate it. There is evidence that students who identify as LGBTQ and manifest gender non conforming behavior do experience more childhood adverse events to a small degree, but, for the most part, gender non conformity does not explain the higher rates of childhood adverse experiences among students who identify as LGBTQ.[45]

- **Family experiences are causal factors in same-sex sexual orientation.** This admission and research leave open the possibility that family dysfunction is a causal factor.[46, 47] The *APA Handbook* affirmed, "Psychoanalytic contingencies are evident as main effects or in interaction with biological factors."[48] There is evidence that LGBTQ identity is associated with higher rates of family dysfunction, for example, parent incarceration,[49] parent problem drinking or abuse of illegal or prescription drugs, psychological and/or physical abuse that may have included witnessing domestic violence, or polyvictimization, and sexual abuse when it was part of polyvictimization.[50]

3. **These findings are more consistent with what some of our clients have claimed,** that they feel their same-sex attraction or behavior was forced on them by childhood sexual abuse or other trauma. Significantly, if these *APA Handbook* corrections of the APA task force's scientific facts are accurate (and the science points toward their being true and shows they cannot be ruled out) then therapy to help people with unwanted same-sex attraction is warranted.

VI. FINDINGS ON GENDER IDENTITY

1. **At least ten U.S. professional organizations, including the American Psychological Association in its *APA Handbook of Sexuality and Psychology,* agree discordant gender identity also develops from a complex mixture of biological and environmental influences**.[51]

2. **At least nine U.S. professional organizations agree that childhood gender dysphoria overwhelmingly resolves naturally by late adolescence or adulthood *if children are supported through puberty and not affirmed as another sex***.[52, 53]

3. The *APA Handbook* and the "Guideline" of the Endocrine Society and its 6 co-sponsoring professional organizations caution that **affirming a child's discordant gender identity may stop natural resolution.**[54]

4. **Some professional organizations and research findings concur that pathological influences may lead to discordant gender identity. Therapy that evaluates for and treats underlying pathological causes may, as a by-product, resolve gender dysphoria. A client's goal of healing underlying causes and potentially becoming able to embrace innate body sex is reasonable and warranted. Criminalizing such therapy that is open to a client's goal of change and**

requiring therapists to affirm or be "neutral" toward gender non conformity that resulted from underlying trauma forbids much needed therapy.

- The **American Psychiatric Association** Task Force on the Treatment of Gender Identity Disorder in 2012 noted that adolescents with gender dysphoria "should be screened carefully to detect the emergence of the desire for sex reassignment in the context of **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" (bold added).[55]

- **The World Professional Association for Transgender Health (WPATH),** in its Standards of Care (2011), said **gender dysphoria may be "secondary to or better accounted for by other diagnoses."**[56] **In that case, WPATH does not recommend body altering interventions. Banning psychotherapy to resolve gender dysphoria leaves therapists and patients few options.**

- The **American Psychological Association's** *APA Handbook of Sexuality and Psychology* says 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**…."[57]

- Rigorous longitudinal research has found that **66% of adolescents experienced a number of other psychiatric disorders, often with hospitalizations for these disorders, during the 6 months leading up to onset of gender nonconformity**. Rates of both these disorders and these hospitalizations were **up to 50 to 70 times higher** than for gender concordant peers of the same sex.[58]

- **Other studies similarly found that psychiatric disorders preceded onset of gender dysphoria.**[59, 60, 61]

5. **The *APA Handbook* 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…[62]

6. **Anecdotal testimonies of trans regretters indicate some who sought help for trauma they felt led to their discordant gender identity tragically received only affirmative "transition" support that led to body harm instead of psychotherapy.** We urge the state never to accept

banning psychotherapy that would help someone resolve gender distress or come to embrace their innate body sex.

7. **Failure to treat underlying trauma** may lead to ongoing trauma, mental health problems,[63, 64, 65] and suicide.[66] Affirming sexual or gender feelings or behaviors caused by trauma is harmful and neglects evaluating for these underlying causes. **Yet the proposed ban allows only for affirmative or "transition" support from therapists.**

8. There is evidence some affirmative therapists are not evaluating for or treating underlying psychiatric disorders and are moving very rapidly to starting GAT.[67]

9. Although research into all approaches to treating gender dysphoria is in a primitive stage, it would seem reasonable to expect that treating pathological influences that lead to a discordant gender identity may as a by-product resolve or change it. **It would certainly be premature to legislate against treatment that may lead to gender congruent identity.**

10. **Therapy that affirms the rejection of one's own body is a path that often leads to a protocol of** experimental[68] puberty-blockers,[69] risky[70] high dose, toxic[71] cross-sex hormones, permanent infertility, potential loss of sexual function, medical dependency for life, healthy breasts removal, potentially surgical destruction of reproductive organs,[72, 73] leading long term to a 2-2.5 times higher rate of deaths from heart disease and cancers, a persisting 2.8 times higher rate of psychiatric hospitalizations, and a 19 times higher rate of *completed* suicides—even in an affirming society.[74] A U.S. government research review said these statistics are from the best available research.[75] **These are astonishing treatment costs and outcomes.**

11. **For these reasons, an increasing number and medical organizations oppose these controversial procedures.**[76] Treating gender dysphoria with evidence-based trauma interventions or well-established psychotherapy practices is safer and therefore should not be banned.

VII. CONCLUSION

We respectfully urge you not to oppose ethical contemporary therapy that is open to clients' goals of change for sexual attraction or behavior or for gender identity or expression they do not want. No one should take away their freedom and their right to develop attractions consistent with their beliefs or goals, to identify as they choose, to live the life that brings them joy – and to have support to do so.

London, January 2020

Endnotes

[1] Sprigg, P. (2018). Are Sexual Orientation Change Efforts (SOCE) Effective? Are They Harmful? What the Evidence Shows, Family Research Council, https://www.frc.org/issueanalysis/are-sexual-orientation-change-efforts-soce-effective-are-they-harmful-what-the-evidence-shows
Read the Full Version (Issue Analysis): https://downloads.frc.org/EF/EF18I04.pdf
Read the Abbreviated Version (Issue Brief Report Summary): https://downloads.frc.org/EF/EF18I05.pdf
Report Summary: What research shows: NARTH's response to the APA claims on homosexuality: Summary of *Journal of Human Sexuality* (Volume I), pp. 1-5. https://www.scribd.com/document/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1.
Full Report: Phelan, J., Whitehead, N., & Sutton, P.M. (2009). What research shows: NARTH's response to the APA claims on homosexuality: A report of the scientific advisory committee of the National Association for Research and Therapy of Homosexuality. *Journal of Human Sexuality, 1:* 1-121. https://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1

[2] Testimonies of change through therapy or faith-based ministries: VoicesOfChange.net, ChangedMovement.com, https://www.exodusglobalalliance.org/firstpersonc7.php , https://www.exodusglobalalliance.org/testimoniesc877.php , SexChangeRegret.com, tranzformed.org. FreeToLoveMovie.com

[3] Ganna, A., et al. (2019). *Science* 365, eaat7693. DOI: 10.1126/science. aat7693 https://www.bbc.com/news/health-49484490
Ganna, A., et al. (2019). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior, *Science, 365,* 882, p. 6. DOI: 10.1126/science. aat769

[4] Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). *APA Handbook of Sexuality and Psychology, 1*:583, 743. Washington D.C.: American Psychological Association.

[5] Ganna, A., et al. (2019). *Science* 365, eaat7693. DOI: 10.1126/science. aat7693 https://www.bbc.com/news/health-49484490
Ganna, A., et al. (2019). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior, *Science, 365,* 882, p. 6. DOI: 10.1126/science. aat769

[6] Identical twins share the same genes, prenatal hormones, and number of older brothers. Identical twins are always the same sex. Sex is 100% determined by genes and prenatal hormones. But if one twin comes to have LGB experiences, discordant gender identity, or discordant gender expression, the other usually does not. This shows that influences other than genes or prenatal hormones are predominant causal factors.
Bailey et al (2016): LGB discordant: pp. 74-76. Non-conforming behavior: pp. 46, 76.
Gender identity discordant: Diamond, M. (2013). Transsexuality among twins: Identity concordance, transition, rearing, and orientation, *International Journal of Transgenderism, 14:*1, 24-38,(Print) 1434-4599 (Online) Journal homepage: http://www.tandfonline.com/loi/wijt20 Journal homepage: http://www.tandfonline.com/loi/wijt20

[7] *APA Handbook,* 1:562, 619, 636.

[8] *APA Handbook*, 1:633.
Savin-Williams, R., Joyner, K., & Rieger, R. (2012). Prevalence and stability of self-reported sexual orientation identity during young adulthood. *Arch Sexual Behavior 41:* abstract, p. 106. https://link.springer.com/article/10.1007/s10508-012-9913-y;
reviewed in Diamond, L. & Rosky, C. (2016). Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research*, 00:1-29. DOI: 10.1080/00224499.2016.1139665), p. 7. See table 1.

[9] Ott, M. Corliss, H., Wypij, D., Rosario, M., Austin, B. (2011). Stability and change in self-reported sexual orientation in young people: Application of mobility metrics. *Arch Sexual Behavior*, 40: 519–532. doi:10.1007/s10508-010-9691-3.
Laumann, E.O., Gagnon, J.H., Michael, R.T., and Michaels, S. (1994). *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago and London: The University of Chicago Press, p. 296.
[10] Genetics of Sexual Behavior: A website to communicate and share the results from the largest study on the genetics of sexual behavior, https://geneticsexbehavior.info/what-we-found/
[11] Ott, et al. (2011).
[12] Of all men who experienced same-sex behavior, 42% did so before age 18 and never again. Laumann, E.O., Gagnon, J.H., Michael, R.T., and Michaels, S. (1994). *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago and London: The University of Chicago Press.
[13] Mock, S. E., & Eibach, R. P. (2012). Stability and change in sexual orientation identity over a 10-year period in adulthood. *Arch Sexual Behavior*, 41, 641–648. doi:10.1007/s10508-011-9761-1
[14] Savin-Williams, Joyner, & Rieger (2012). 41: abstract, p. 106.
[15] Dickson, N., Paul, C., & Herbison, P. (2003). Same-sex attraction in a birth cohort: Prevalence and persistence in early adulthood. *Social Science and Medicine*, 56, 1607–1615. doi:10.1016/S0277-9536(02)00161-2
[16] APA Task Force Report (2009). 40-50 years – since about the 1960's or 1970's: pp. 22, 82.
[17] Professor Clifford Rosky (March 1, 2019). testimony on "conversion therapy" bill at House Judiciary Standing Committee hearing, Salt Lake City, Utah, USA. He said, "One of the amendments would exclude talk therapy and focus only on what they call aversive practices like electric shock therapy. Licensed therapists haven't been doing electric shock therapy and aversive practices for decades. Nobody's doing that anymore."
[18] Alliance Practice Guidelines Task Force (2017). Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy, Alliance for Therapeutic Choice and Scientific Integrity Task Force on Guidelines fo the Practice of Sexual Attraction Fluidity Exploration in Therapy (SAFE-T), https://a20ceadd-0fb7-4982-bbe2-099c8bc1e2ae.filesusr.com/ugd/ec16e9_68b6f7dbe5bc4daab554c37ee9bcf29f.pdf
[19] International Federation for Therapeutic Choice and Scientific Integrity, Standards, https://iftcc.org/standards/
[20]APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Washington, DC: American Psychological Association, No causal evidence of harm: 42, 82, 91. Reported change or harm: 49, 85. No studies reporting harm met task force scientific standards.
[21] Any discussion of alleged harms also must be placed in the broader context of psychotherapy outcomes in general. Extensive research has shown that 5–10 percent of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates—sometimes exceeding 20 percent—have been reported for children and adolescents in psychotherapy (Lambert 2013; Lambert and Ogles 2004; Nelson et al. 2013). Deterioration rates would need to be established for professionally conducted change allowing therapy significantly beyond 10 percent for adults and 20 percent for youth in order for claims of approach-specific harms to be substantiated. There is no evidence for this.
[22] Federal judge's decision: http://lc.org/PDFs/Attachments2PRsLAs/100419TampaOrderGrantingMSJ.pdf , p. 32.
[23] See endnote 1
[24] See endnote 2
[25] MEDICAL AND MENTAL HEALTH PROFESSIONAL ORGANIZATIONS have opposed bans on therapy that is open to a client's goal of change for unwanted sexual orientation or unwanted gender identity and/or supported the right of clients to such therapy:

- International Federation for Therapeutic and Counseling Choice (https://iftcc.org/standards/),
- International Federation of Catholic Medical Associations (FIAMC)

— has 65 member organizations around the world,

- International Network of Orthodox Mental Health Professionals [Jewish],

4 Organization Joint Statement – American College of Pediatricians, American Association of Physicians and Surgeons, Christian Medical and Dental Association, and Catholic Medical Association – Support Minors' Right to Therapy (5-25-2017), (https://www.acpeds.org/wordpress/wp-content/uploads/5.25.17-Joint-Therapy-letter-with-signatures.pdf),

- American Association of Physicians and Surgeons (https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/),
- American College of Pediatricians (https://drive.google.com/file/d/0B9njBaZTrCfSZ09tRDFQaVVFN1hqVnpHb3I5RTlqcTI5bHlB/view),
- Christian Medical and Dental Association (see joint statement),
- Catholic Medical Association (https://www.cathmed.org/resources/cma-protests-california-bill/),
- Society of Catholic Social Scientists,
- Alliance for Therapeutic Choice and Scientific Integrity (https://docs.wixstatic.com/ugd/ec16e9_1d6108cfa05d4a73921e0d0292c0bc91.pdf)
- American Association of Christian Counselors (AACC Code of Ethics, 2014, 1-120f, 1-330, 1-340, https://www.aacc.net/code-of-ethics-2/),
- Association of Christians in Health and Human Services.

[26] Ryan, C., Toomey, R., Diaz, R., & Russell, S. (2018). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment, *J. of Homosexuality*, DOI:10.1080/00918369.2018.1538407, published online Nov. 7, 2018.

[27] Haynes, L. (Sept. 16, 2019). Are Religious Californians Really Harming the Mental Health of People Who Identify as LGBTQ? https://www.thepublicdiscourse.com/author/laura-haynes/

[28] Barringer, M., Gay, D. (2017). Happily religious: The surprising sources of happiness among lesbian, gay, bisexual, and transgender adults, *Sociological Inquiry, 87*, 75–96, DOI: 10.1111/soin.12154

[29] Stephen C. (2017). The LGB Mormon Paradox: Mental, Physical, and Self-Rated Health Among Mormon and Non-Mormon LGB Individuals in the Utah Behavioral Risk Factor Surveillance System, *J. of Homosexuality*, 64:6, 731-744, DOI: 10.1080/00918369.2016.1236570

[30] Lefevor, G., Sorrell, S., Kappers, G., Plunk, A., Schow, R., Rosik, C., & Beckstead, A. (2019). Same-Sex Attracted, Not LGBQ: The Associations of Sexual Identity Labeling on Religiousness, Sexuality, and Health Among Mormons, *J. of Homosexuality*, DOI: 10.1080/00918369.2018.1564006

[31] Lefevor, G., Beckstead, L., Schow, R., Raynes, M., Mansfield, T., Rosik, C. (2019). Satisfaction and health within four sexual identity relationship options, *J. of Sex and Marital Therapy*, http://www.tandfonline.com/action/showCitFormats?doi=10.1080/0092623X.2018.1531333

[32] U. S. Department of Health and Human Services, Centers for Disease Control and Prevention (2017). Youth Risk Behavior Surveillance – United States, 2017, Morbidity & Mortality Weekly Report, June 15, 2018, Surveillance Summaries, 67(8). https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf

[33] Ganna, A., et al. (2019). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior, *Science,* 365, 882, p. 4-5. DOI: 10.1126/science. aat769

[34] Nicolosi J., Byrd, A., Potts, R. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86*:1071-1088.

[35] Karten, E.Y., & Wade, J.C. (2010). Sexual Orientation Change Efforts in Men: A Client Perspective. Journal of Men's Studies, 18(1), 84-102. DOI: 10.3149/jms.1801.84
[36] APA Task Force Report (2009). p. 86.
[37] Rosik, C. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* apply its research standards consistently? A preliminary examination. *J. of Human Sexuality, 4*:70-85. http://media.wix.com/ugd/
[38] *APA Handbook,* 1:xvi.
[39] *APA Handbook*, 1:636, 562, 619.
[40] *APA Handbook,* 1:609-610.
[41] Wilson, H. & Widom, C. (2010). Does physical abuse, sexual abuse, or neglect in childhood increase the likelihood of same-sex sexual relationships and cohabitation? A prospective 30-year follow-up, *Arch Sexual Behavior*, 39: 63-74, DOI 10.1007/s10508-008-9449-3
[42] Many studies show an association between childhood sexual abuse and same-sex sexuality (1 of 3 notes).
Andersen, J. P., & Blosnich, J. (2013). Disparities in adverse childhood experiences among sexual minority and heterosexual adults: Results from a multi-state probability-based sample. *Plos One, 8*, 1-7. http://dx.doi.org/10.1371/journal-pone.0054691
Artime, T. M., McCallum, E. B., & Peterson, Z. D. (2014). Men's acknowledgment of their sexual victimization experiences. *Psychology of Men & Masculinity*, *15*, 313-323. http://dx.doi.org/10.1037/a0033376
Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics, 141(5),* e20173004. http://pediatrics.aappublications.org/content/early/2018/04/12/peds.2017-3004
Beard, K. W., O'Keefe, S. L., Swindell, S., Stroebel, S. S., Griffee, K., Young, D. H., & Linz, T. D. (2013). Brother-brother incest: Data from an anonymous computerized survey. *Sexual Addiction & Compulsivity, 20*, 217-253. http://dx.doi.org/10.1080/10720162.2013.807483.
Bickham, P. J., O'Keefe, S. L., Baker, E., Berhie, G., Kommor, M. J., & Harper-Dorton, K. V. (2007). Correlates of early overt and covert sexual behaviors in heterosexual women. *Arch. of Sexual Behavior, 36*, 724-740. http://dx.doi.org/10.1007/s10508-007-9220-1
Brown, M. J., Masho, S. W., Perera, R. A., Mezuk, B., & Cohen, S. A. (2015). Sex and sexual orientation disparities in adverse childhood experiences and early age at sexual debut in the United States: Results from a nationally representative sample(). *Child Abuse & Neglect*, *46*, 89–102.
CONTINUED NEXT ENDNOTE.
[43] Many studies show an association between childhood sexual abuse and same-sex sexuality, continued.
Cooper, P. J., Pauletti, R. E., Tobin, D. D., Menon, M., Menon, M.,…& Perry, D. G. (2013). Mother-child attachment and gender identity in preadolescence. *Sex Roles, 69*, 618-631. http://dx.doi.org/10.1007/s11199-013-0310-3
Corliss, H. L., Cochran, S. D., & Mays, V. M. (2002). Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual, and heterosexual adults. *Child Abuse & Neglect*, *26*(11), 1165
Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E. M., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am. J. of Public Health, 101*, 1481-1494. http://dx.doi.org/10.2105/AJPH.2009190009
Hoffman, H. (2012). Considering the role of conditioning in sexual orientation. *Arch. of Sexual Behavior, 41*, 63-71. http://dx.doi.org/s10508/012-9915-9
Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality.* Chicago, IL: University of Chicago Press.

Laumann, E. O., Michael, R. T., & Gagnon, J. H. (1994). A political history of the national sex survey of adults. *Family Planning Perspectives, 26*, 34-38.
McLaughlin, K. A., Hatzenbuehler, M. L., Xuan, Z., & Conron, K. J. (2012). Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. *Child Abuse & Neglect*, *36*(9), 645–655.
Mustanski, B., Kuper, L., and Geene, G. (2014) Chapter 19: Development of sexual orientation and identity. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology, Volume 1. Person Based Approaches.* Washington D.C.: American Psychological Association. Research commentary, pp. 609-610.
O'Keefe, S. L., Beard, K. W., Swindell, S., Stroebel, S. S., Griffee, K., & Young, D. H. (2014). Sister-brother incest: Data from anonymous computer assisted self interviews. *Sexual Addiction & Compulsivity, 21*, 1-38. http://dx.doi.org/10.1080/10720162.2013.877410
Outlaw, A. Y., Phillips, G., Hightow-Weidman, L. B., Fields, S. D., Hidalgo, J.,…& Green-Jones, M. (2011). Age of MSM sexual debut and risk factors: Results from a multisite study of racial/ethnic minority YMSM living with HIV [Supplement 1]. *AIDS patient care and STDs, 25*, S23-S29. http://dx.doi.org/10.1089/apc.2011.9879
Paul, J. P., Catania, J., Pollack, L., & Stall, R. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study1☆. *Child Abuse & Neglect*, *25*(4), 557–584
Purcell, DW, C, RM, Dolezal, C, Carballo-Dieguez, A (2004). Sexual abuse of boys: Short- and long-term associations and implications for HIV prevention. In Eds. Koenig, LJ, Doll, LS, O'Leary, A, and Pequegnat, W. (2004). From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention. American Psychological Association.
Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systemic review. *Trauma, Violence, & Abuse, 12*, 55-66. http://dx.doi/org/10.1177/1524838010390707
Sweet, T., & Welles, S. L. (2012). Associations of sexual identity or same-sex behaviors with history of childhood sexual abuse and HIV/SDI risk in the United States. *Journal of Acquired Immune Deficiency Syndromes, 59*, 400-408. http://dx.doi.org/10.1097/QAI.0b013e3182400e75
Tomeo, M. E., Templer, D. I., Anderson, S., & Kotler, D. (2001). Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons. *Arch Sex. Behavior*, *30*(5), 535–541.
Wilson, H. W., & Widom, C. S. (2010). Does physical abuse, sexual abuse, or neglect in childhood increase the likelihood of same-sex sexual relationships and cohabitation? A prospective 30-year follow-up. *Archives of Sexual Behavior, 39,* 63-74. http://dx.doi.org/ 10.1007/s10508-008-9449-3
CONCLUDED NEXT ENDNOTE.
Zietsch, B. P. (2012). Explanations for elevated psychiatric vulnerability in nonheterosexuals. Environmental stressors, genetics, and the HPA and HPG axes. In T. Uehara (Ed.) *Psychiatric disorders: Worldwide advances* (pp. 277-300). Rijeka, Croatia: InTech.
[44] Many studies show an association between childhood sexual abuse and same-sex sexuality, concluded.
Xu, Y., & Zheng, Y. (2015). Prevalence of childhood sexual abuse among lesbian, gay, and bisexual people: A meta-analysis. *Journal of Child Sexual Abuse, 24*, 315-331. http://dx.doi.org/10.1080/10538712.2015.1006746
Zietsch, B. P. (2012). Explanations for elevated psychiatric vulnerability in nonheterosexuals. Environmental stressors, genetics, and the HPA and HPG axes. In T. Uehara (Ed.) *Psychiatric disorders: Worldwide advances* (pp. 277-300). Rijeka, Croatia: InTech.
[45] Baams (2018).
[46] *APA Handbook,* 1:583.

[47] Absence of a parent, especially the parent of a same-sex child, is a small but significant and potentially causal factor found internationally for same-sex attraction, behavior, and same-sex marriage. Found in several large, robust, population-based, prospective, longitudinal studies below:
The first 6 years of life for both sexes and adolescence for girls may be sensitive periods (Frisch & Hviid, 2006)
Fergusson, D., Horwood, L., Beautrais, A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Arch General Psychiatry, 56*:p. 878.
Francis, A. M. (2008). Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. *J. Sex Research, 45* (4), 371-377. http://www.tandfonline.com/doi/full/10.1080/00224490802398357?scroll=top&needAccess=true
Frisch, M. & Hviid, A. (2006). Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes. *Arch Sexual Behavior,* 35, pp. 533-547. https://link.springer.com/article/10.1007/s10508-006-9062-2
Frisch, M. & Hviid, A. (2007). Reply to Blanchard's (2007) "older-sibling and younger-sibling sex ratios in Frisch and Hviid's (2006) national cohort study of two million Danes," *Arch Sexual Behavior,* 36:864-867.
Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same- sex and opposite-sex interest. *J. Biosocial Science*, 37, 481–497. http://dx.doi.org/10.1017/S0021932004006765
[48] Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics*, 141(5): e20173004. http://pediatrics.aappublications.org/content/early/2018/04/12/peds.
LGBT youth were more likely to have grown up with household dysfunction defined by parent incarceration, problem drinking, or abuse of illegal or prescription drugs. This is included in both the household dysfunction and poly-victimization groups. But not significant for Q youth, p. 3.
LGBTQ youth more likely to experience psychological and/or physical abuse that may have included witnessing domestic violence (p. 4) and poly-victimization that adds to household dysfunction and sexual abuse.
Gender nonconforming adolescents, especially bisexuals, had experienced more types of abuse.
Transgender identity, especially for boys, was associated with more kinds of adverse experiences (household dysfunction, physical and/or sexual abuse, and poly-victimization, p. 6).
Sexual orientation and gender identity are generally confounded with gender nonconformity. However, this study specifically measured gender nonconformity separately and controlled for it, making it possible to reveal that the association between LGBTQ youth and adverse experiences is not simply explained by gender nonconformity. pp. 6-7.
Gender nonconforming adolescents (especially bisexual and transgender identified) had experienced more types of adverse experiences. However, gender nonconformity was not the only explanation for adverse experiences (p. 7).
[49] Fergusson, et al. (1999), parent incarceration.
[50] Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. Pediatrics, 141(5): e20173004. http://pediatrics.aappublications.org/content/early/2018/04/12/peds.

LGBT youth were more likely to have grown up with household dysfunction defined as parent incarceration, problem drinking, or abuse of illegal or prescription drugs (p. 3).

LGBTQ youth were more likely to experience psychological and/or physical abuse that may have included witnessing domestic violence (p. 4) or to have experienced polyvictimization. Sexual abuse had a role when it was part of polyvictimization.

Gender nonconforming adolescents, especially bisexuals, experienced more types of abuse. Transgender identity, especially for boys, was associated with more kinds of adverse experiences (household dysfunction, physical and/or sexual abuse, and polyvictimization) (p. 6).

Sexual orientation and gender identity are generally confounded with gender nonconformity. This may be the first study that specifically measured gender nonconformity separately and controlled for it, making it possible to reveal that the association between LGBTQ identified youth and adverse childhood experiences is not simply explained or caused by their gender nonconformity (pp. 6-7).

Gender nonconformity had a significant but small role in their adverse experiences as a cause, result, or something else. But It could not possibly have been the only or even nearly the primary cause of their adverse childhood experiences.

[51] These 10 U.S. professional organizations agree gender non conformity is not simply biologically determined:
Hembree, W., et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guildeline. *J Clin Endocrinol Metab*, 102:1–35, https://academic.oup.com/jcem , p. 6-7.
Six co-sponsoring Associations with the Endocrine Society: Amer. Assn. of Clinical Endocrinologists, Amer. Soc. of Andrology, Eur. Soc. for Pediatric Endocrinology, Eur. Soc. of Endocrinology, Pediatric Endocrine Soc., and World Prof. Assn. for Transgender Health.
The American Psychological Association's *Handbook of Sexuality and Psychology* says transgender identity is not simply biologically determined, has psychological causes, and may be pathological. Affirmative treatment may neglect individual problems gender dysphoric minors are experiencing. *APA Handbook, 1*: 743-744, 750.
American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Association, pp. 451-459. See especially pp. 451, 457.
Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness (2018). Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents. *Pediatrics 142(4)*: e20182162. P. 4, see also p. 4.

[52] Hembree, et al., (2017), p.11. DSM-5, p. 455. *APA Handbook*, 1:744.
Cohen-Kettenis P, Delemarre-van de Waal, H., & Gooren L. (2008), The treatment of adolescent transsexuals: Changing insights, J Sex Med, 5:1892–1897, DOI: 10.1111/j.1743-6109.2008.00870.x)
Zucker, K. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018), *Int. J. of Transgenderism*, pp. 2-3, 11, https://doi.org/ 10.1080/15532739.2018.1468293)

[53] Hembree, et al. (2017), p. 11. *APA Handbook*, 2014, 1:744, 750.
Laidlaw, M. (Oct. 24, 2018), The gender identity phantom, http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/

[54] Hembree, et al. (2017), p. 11., *APA Handbook* (2014), 1:750.

[55] Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle EJ, et al. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Archives of Sexual Behavior. 2012; 41: 759–796. https://doi.org/10.1007/s10508-012-9975-x PMID: 22736225

[56] World Professional Association for Transgender Health (WPATH) (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, https://wpath.org/publications/soc , p. 24.

[57] Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) APA Handbook of Sexuality and Psychology, Washington D.C.: American Psychological Association, vol. 1, p. 743.
[58] Becerra-Culqui TA, Liu Y, Nash R, et al. Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers. Pediatrics. 2018;141(5):e20173845
[59] Similar results support findings of Becerra-Culqui:
Kaltiala-Heino, R., Sumia, M., Työläjärvi, M. and Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health, 9:9,
DOI 10.1186/s13034-015-0042-y
[60] Littman L (2018) Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. PLoS ONE 13(8): e0202330. https://doi.org/10.1371/journal. pone.0202330
[61] Zucker, K., Wood, H., Singh, D., & Bradley, S. (2012), Journal of Homosexuality, 59:369–397, online DOI: 10.1080/00918369.2012.653309
[62] *APA Handbook*, *1*: 743-744, 750.
[63] *APA Handbook*, *1*: 744, 750.
[64] Becerra-Culqui, et al. (2018).
[65] Dhejne (2011).
[66] Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003). Psychological autopsy studies of suicide: a systematic review, *Psychological Medicine*, 33: Abstract, p. 402, Cambridge University Press, DOI: 10.1017/S0033291702006943
Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslvsky, A., and Kessler, R. (2013). Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication – Adolescent Supplement (NCS-A), *JAMA Psychiatry*, 70(3): p. 18, Table 3, doi:10.1001/2013.jamapsychiatry.55.
[67] Littman (2018).
[68] Thus far, there is no such research. The first such research is scheduled to be completed in 2020. It will only follow patients for 5 years, not long enough to give long term/endpoint outcomes on health and mental health.
Olson, J., Garofalo, R., Rosenthal, St., Spack, N. (2015-2010). The Impact of Early Medical Treatment in Transgender Youth. National Institutes of Health. (Grant study description.)
http://grantome.com/grant/NIH/R01-HD082554-01A1
[69] Gagliano-Juca, T., Traveison, T., Kantoff, P. Nguyen, P. L., Taplin, M-E, Kibel, A., Huang, G., Bearup, R., Schram, H., Manley, R., Beleva, Y., Edwards, R., Basaria, S. (2018). Androgen Deprivation Therapy is Associated with Prolongation of QTc Interval in Men With Prostate Cancer. Journal of the Endocrine Society, 2: 485-496.
Hembree, et al. (2017), pp. 14-15.
Laidlaw, M., Van Meter, Q., Hruz, P., Van Mol, A., & Malone, W. (2019). Letter to the editor: "Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society clinical practice guideline," J Clin Endocrinol Metab, March 2019, 104,3: 686-7.
[70] WPATH Standards of Care (2011), p. 24.
Hembree, et al., (2017): See ratings (indicated by a row of circles).
[71]WPATH, Standards of Care (2011), pp. 37-40, 50, 97-104.
Hembree et al. (2017), pp. 21-25.
Laidlaw, M. (Oct. 24, 2018). The gender identity phantom, http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/ Endocrinologist, expert witness to CA legislators.
[72] Hembree, et al, (2017).

[73] WPATH Standards of Care (2011).
[74] Dhejne C, Lichtenstein P, Boman M, Johansson ALV, La ̊ngstro ̈m N, et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE* 6(2): e16885. doi:10.1371/journal.pone.0016885.
[75] Centers for Medicare & Medicaid Services (August 30, 2016). Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), p. 62, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282.
[76] Multiple medical groups throughout the world, including the Royal College of General Practitioners, the Swedish Pediatric Society and the Royal Australian College of Physicians have warned against these "gender affirmative" interventions.
See also: gdworkinggroup.org
YouthTransCriticalProfessionals.org