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

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INTERNATIONAL FOUNDATION FOR THERAPEUTIC & COUNSELLING CHOICE

February 23, 2025

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

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The Coalition Against Conversion Therapy
Memorandum of Understanding on Conversation Therapy in the U.K.
By Laura Haynes, Ph.D.

TABLE OF CONTENTS

PROBLEMS WITH THE MoU

I.INTRODUCTION

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

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

3. This Summary Expert Report with selected references is from a Full Expert Report that is posted at iftcc.org for more discussion of research and references as may be desired.

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

4. **The Memorandum of Understanding (MoU) in the U.K. prohibits a mental health professional from providing therapy that helps a client reduce distress about undesired or unfulfilling same-sex sexuality or discordant gender identity and that may or may not result in reduced same-sex behaviour, some degree of change in sexual attraction feelings, or a gender identity that more closely aligns with the person's sex when the desire for therapy is based on a "viewpoint" that one sexual orientation or gender identity is preferable to another.[1] The MoU is viewpoint discrimination and polices a client's or a therapist's thoughts as well as consensual therapy conversations or speech based thereon. A result is that the MoU polices values, beliefs, ethics, conscience, life goals, sexual feelings, sexual behaviours, gender identity, gender expression, many religions, and many cultures.**

5. **One may note that there is an MoU on Conversion Therapy on the Island of Ireland (2024) that is essentially identical to the U.K. MoU resulting in the same harms.**

6. **Ethical contemporary therapists who help clients decrease gender or sexuality distress and are open to their desire for options to unfulfilling or undesired same-sex sexuality or discordant gender identity generally do not use the terms** "conversion therapy" or "gay cure therapy", political utility terms. These therapists oppose therapist-imposed therapy goals, aversive and coercive methods, and guarantees of therapy outcomes wherever they may exist[2].

7. **The United Kingdom Council for Psychotherapy acknowledges *sexual attraction change may occur during the course of psychological interventions*[3]**, as research presented in this report supports, but the MoU accepts such change only if there is no

[1] The MoU on Conversion Therapy on the Island of Ireland (2024) states essentially the same as the MoU UK.
[2] IFTCC Practise and Ethical Guidelines (PEG), 2023, preamble.
[3] UKCP, no date, guideline 3.3, emphasis added.

goal of change and no *viewpoint* that one sexual attraction is better than another. It would be next to impossible to prove the therapy has no influence in such changes.

8. **The MoU lacks clarity and appears discriminatory.**

    a. **May a therapist provide distress-reducing, change-allowing therapy that may or may not result in decrease or change in sexual or gender feelings or behaviours if neither client nor therapist holds an unapproved viewpoint or never? Some clients want this therapeutic help** (1) to protect health—for example to decrease same-sex partners in order to reduce risk of HIV transmission[4], (2) to help an applicant to a Catholic seminary suppress same-sex expression, (3) to reduce behaviour that meets diagnostic criteria for a recognised psychiatric disorder[5], (4) to overcome sexual or gender behaviours that the person feels emerged from sexual[6] or gender[7] trauma and do not represent the person's authentic self, (5) to help detransitioners resolve core gender dysphoria and mental health problems after affirmative medical gender interventions did not help these[8]; (6) to protect an opposite-sex marriage from same-sex or gender discordant expression that is placing the marriage at risk and to hold a family together[9], or (7) to move away from behaviours a person finds unfulfilling.

    b. **The MoU discriminates against distressed people of traditional religions** who may wish the same interventions as others in order to live more consistently with their preferences, values, and beliefs that are not MoU approved.

    c. **It would be absurd to prohibit therapy for each and every one all these client goals. If some people are permitted therapy that reduces distress and may or may not result in changes in sexuality or gender feelings or behaviours for some reasons, anyone should be permitted such help for whatever reasons they wish without viewpoint discrimination or religious discrimination.**

9. **By mandating one viewpoint**, the MoU harmfully stifles potential for advances in clinical, multi-cultural, theoretical, and research work.

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[4] Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Nyamathi et al., 2017.

[5] Example, the International Classification of Diseases, 11th Edition, recognises Compulsive Sexual Behaviour Disorder (WHO, 2022).

[6] Mustanski, Kuper, & Greene, 2014, in *APA Handbook of Sexuality and Psychology*, *vol. 1*, pp. 609-610; Wilson & Widom, 2010; Zietsch et al., 2012; Nicolosi, Byrd, & Potts, 2000.

[7] Taylor et al., 2024, Characteristics of childhood and adolescents referred to specialist gender services: a systematic review, conducted at York University for the Cass Review for NHS-England; Cass, April 2024, 8.42 on pp. 119-120; Byne et al., 2012, p. 764; Vandenbussche, 2021; Littman, 2021.

[8] Vandenbussche, 2021; Littman, 2021.

[9] See research on high rate of relationships of same-sex attracted people are with the opposite sex at "V. Same Sex Attraction, Behaviour, and Identity Can Change…"; change-allowing therapy effective for fathers (Nyamathi et al., 2017) and men in opposite-sex marriages, most of whom are fathers (Sullins & Rosik, 2024).

10. **The MoU prohibits sexual self-determination** which is part of the fundamental freedom of the individual. Instead, the MoU predetermines what goals clients may have regarding matters as deeply personal as their own sexuality and gender identity.

11. **The Cass Review reported that, due to the MoU therapy ban and the threat of a legislative ban, some therapists have declined to risk treating gender dysphoric young people at all** and instead have referred large numbers to the Tavistock where they were left untreated on a long waiting list, overwhelmed the Tavistock, and ultimately contributed to closing it. Dr. Cass has reported continuing difficulty recruiting and training therapists for gender dysphoric children. **The Foundation for Therapeutic and Counselling Choice has heard from therapists and from individuals distressed about same-sex sexuality that many in this population are also dangerously not being seen for help.**[10] Bans have markedly reduced access to care for the very people they intend to help. Therapy bans have not been helpful.

12. **To justify enforcing MoU viewpoint discrimination against clients and therapists with such wide-reaching effects, there should be incontrovertible scientific evidence.**

III. NO SUPPORTING RESEARCH OFFERED BY THE MoU VERSION 2 AND LIMITED RESEARCH FROM VERSION 1 AND RELATED DOCUMENTS REGARDING SEXUALITY AND GENDER CHANGE

13. **The current MoU, Version 2, offers no original research or research review of its own or indeed any research references in support of its viewpoint or even references at all.** It refers to the latest British Psychological Society guidelines[11] for training purposes that refers back to the MoU, Version 2 and some version 1 references.

14. **The original version of the MoU (version 1) had 7 footnotes containing 6 references to any original research or research review. These do not provide valid evidence in opposition to change-allowing therapy**.

    a. A "United Kingdom Council for Psychotherapy (UKCP) Conversion Therapy Consensus Statement" said it is unethical to treat a condition that is not an illness, yet said the signatories accept specialist support for significant stress for bereavement, employment, or relationship difficulties which are not illnesses.[12] In an even more remarkable contradiction to this criticism, MoU version 2 signatories accept potentially permanent, body-harming and health-risking treatment for gender incongruence that they regard as not an illness.[13]

    b. Three research reviews discouraged change-allowing therapy due to methods limitations of research in support of such therapy but uncritically accepted affirmative therapy studies and studies claiming harm from change-allowing therapy that had the same research limitations, as did all research on services

[10] Cass, 2022, p. 47, 48; 2024, 17:20-23. IFTCC, 2024.
[11] BPS Guidelines, 2019, refers to the MoU Version 2, King et al., 2007, and Shaw et al., BPS Guidelines, 2012.
[12] UKCP, 2014.
[13] MoU, July 2024.

or therapy for LGBT identified people then.[14] Critics applied their standards inconsistently to studies with outcomes they did not prefer compared to studies with outcomes they preferred. Researchers said clients judged any attempt to change very negatively[15] but did not include in their research clients who desire change and judge attempts to affirm very negatively.[16]

c. **A Royal College of Psychiatrists critique said sexual orientation is biologically determined, then corrected this in a subsequent paper.[17]**

d. **Research reviewers acknowledged that aversive "conversion therapy" methods had been discontinued and were historical,[18] then some focused on them at length.**

e. An early British Psychological Society guideline [19] offered 2 citations questioning change-allowing therapy--one about long-ago discontinued behaviouristic methods, the other a representative therapist survey finding that 72% of therapists who actually had had experience providing sexuality change-allowing therapy supported it. The guideline cited articles on therapies regarding transgender patients that had no goal of gender identity change[20].

f. A relevant document not referenced in the editions of the MoU, namely the UK Council for Psychotherapy's "Ethical Principles and Codes of Conduct: Guidance on the Practice of Psychological Therapies that Pathologise and/or Seek to Eliminate or Reduce Same-sex Attraction", offered one reference on change-allowing therapy that appears to be an out-of-date book.[21]

15. **A MoU on Conversion Therapy on the Island of Ireland has no research references**.[22]

16. **An American Psychological Association 2009 report referenced in the original 2015 MoU, therefore, may come closest to being research on which censoring change-allowing therapy might be scientifically based in the MoU. It critiques change efforts for sexual orientation but not gender identity. The APA Report said it was "built" on what it claimed was a "key" scientific finding, that only sexual identity (self-label) changes, but sexual orientation (meaning sexual attraction here) does not change through life events.[23] Therefore, it is unlikely to change through therapy and attempts to change it may be harmful. The view that sexual attraction is unchangeable implies a view that it is biologically determined and therefore fixed. I**

[14] King et al., 2007.
[15] King et al., 2007; Serovich et al., 2008; APA task force Report, 2009.
[16] Nicolosi, Byrd, & Potts, 2000; Throckmorton & Welton, 2005, p. 16; SCIO, March 2024.
[17] Is biologically determined: RCPsych, n.d.. Is not biologically determined: RCPych, 2014.
[18] Bartlett et al., 2009; Serovich et al., 2008; APA task force, 2009.
[19] BPS, 2012, pp. 18, 25.
[20] Meyer et al. 2001; Seikowski, 2007.
[21] U.K. Council for Psychotherapy (UKCP) (no date). UKCP's ethical principles.
[22] MoU Ireland, 2024. States essentially the same content as the MoU U.K. version 2.
[23] American Psychological Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), sexual orientation meant attraction: pp. 54-55, does not change through life events: pp. 63, 86.

will critique a view that same-sex sexuality and discordant gender identity are inborn and do not change next and will critique the APA Report and MoU on other points in due course.

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

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

18. **Views of causes of same-sex sexuality and discordant gender identity go to the heart of the controversies over the appropriate clinical response.**

19. **The combined findings of mutually confirmatory, largest-ever, most statistically powerful, quantitative, peer-reviewed, gene studies using different research methods—a genome-wide association study, a study of genetically confirmed close relatives[24], and a meta-analysis of 50 years of twin studies[25]—have found that genes contribute about 32% of the influences toward the development of same sex sexuality. *Genes would never be the sole factor leading to same sex sexuality.* The gene analysis researchers concluded,** "Behavioral traits, like sexual behavior and orientation, are only partially genetic in nature. They are shaped by hundreds or thousands of genetic variants, each with a very small effect, yet they are also shaped in large part by a person's environment and life experiences. We can therefore say with confidence that there is neither a single genetic determinant of nor single gene for same-sex sexual behavior or sexual orientation." They also explained that "knowing someone's genetic information allows us to guess their sexual behavior just about as well as guessing with no genetic information at all". They further said, "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."[26]

20. **In the largest-ever twin study, this 32% genetic influence was below average for all traits studied (49% [27]) and for all psychiatric traits studied (46% [28]) that psychotherapists help people manage, reduce, or change regularly.**

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[24] Ganna et al., 2019a, 2019b.

[25]32%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "ICF/ICD 10 Subchapter"; under "Acquired Absence of Organs…" choose "Psychological and behavioural…sexual development and orientation"; scroll down to "*h*2_all" = 0.32. "*h*2 all" = genetic contribution or heritability for all; "ss" = "same sex;" "m" = "male;" and "f" = "female." (Polderman, no date)

[26] Ganna et al., 2019b, What We Found.

[27] 49%: Polderman, 2015, p. 1; go to end of article link to http://match.ctglab.nl/#/specific/plot1 ; "under All Traits" scroll all the way down to "*h2*_all" = 0.49. Polderman et al. (no date).

[28] 46%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "Domain;" under "Activities" choose "Psychiatric;" scroll all the way down to "*h*2_all" = 0.46. (Polderman, no date)

21. **The genetic contribution to same-sex sexuality, 32%, was virtually the same as the genetic contribution to religion and spirituality, 31%[29]. There is no genetic reason why a person's same-sex sexuality should be treated as more truly who a person is than a person's religious self when there is a conflict between them.**

22. **Hypotheses that genes and prenatal biological influences such as hormones, epigenetics, or maternal factors [30] determine same-sex sexuality or gender discordant identity are actually theories that such influences cause a boy to be born less masculine or a girl to be born more masculine. These gender atypical traits, however, do not equal and do not inevitably lead to same-sex attraction feelings[31] or discordant gender identity[32]. More influences are needed to develop same-sex sexuality or gender discordance. Biological determinism of same-sex sexuality and discordant gender identity has not been scientifically substantiated, and there is not a professional consensus in support of this view**.[33]

23. **A person cannot be born with a brain of the opposite sex.** Some brain features are strictly sexually dichotomised without exception[34], and some are on a spectrum and shared across sexes[35]. According to a global consensus statement of endocrine societies, there is no consistent evidence that the brains of gender identity discordant people are different from the brains of people who identify with their sex.[36]

24. **A person is not born with a brain that is fixed from birth.**[37]Sexuality and gender identity develop and change through life experiences throughout the life span. What we think about and do[38] and even psychotherapy change the brain[39].

25. **The finding that same-sex sexuality and gender discordance are not simply biologically determined but change and develop lifelong through a complex interplay of biological, psychological, social, and cultural experiences opens inquiry concerning appropriate clinical response to individuals distressed by their same-sex attraction or discordant gender identity and desiring to explore their potential for these to become more nearly congruent with their sex and life goals.**

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[29] 31%: Polderman et al., 2015, go to link at end of article: http://match.ctglab.nl/#/specific/plot1 ; Under "All Traits" choose "ICF/ICD 10 Subchapter;" under "Acquired Absence of Organs…" choose "Religion and Spirituality;" scroll down to "*h*2_all" = 0.31. (Polderman, no date)

[30] Example the fraternal birth order (FBO) effect or maternal immune hypothesis, Bogaert et al., 2017.

[31] Bailey et al., 2016, p. 76; Jordan-Young, 2012.

[32] Bockting, 2024, vol. 1, pp. 743-744; Jordan-Young, 2012.

[33] Jordan-Young, 2010; 2012; American Psychological Association: Tolman & Diamond, 2014, vol. 1, pp. 583, 743; Endocrine Society: Bhargava et al., 2021, p. 227; American Psychiatric Association: Byne, 2012, p. 264; American Psychiatric Association, 2012; 2022, p. 517; Cass, April 2024, Final Report, p. 115; More research-based discussion in Full Expert Report at "IV: Same Sex Attraction and Incongruent Gender Identity Not 'Born That Way'".

[34] Ryali et al., 2024.

[35] Bhargava et al., 2021, pp. 233, 236; Joel et al., 2015, abstract.

[36] Lee, Nordenstrom, et al., 2016.

[37] Jordan-Young, 2010.

[38] Bhargave et al., 2021, pp. 233, 236.

[39] Vinkers et al., 2019.

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

26. **The APA task force Report of 2009** referenced in the original MoU**,** recommending LGB-identity-affirming therapy and discouraging change-allowing therapy, **claimed its conclusions and recommendations were based in part on what the task force characterised as a "key" scientific finding that sexual orientation does not change through life events**.[40] If that were true, it could not change through therapy.

27. **Five years after the APA task force report, the American Psychological Association acknowledged that sexual attraction, behaviour, and identity all commonly change for men and women, adolescents and adults, over the lifespan based on research**.[41] The American Psychiatric Association concurs[42], and the Royal College of Psychiatry came to agree at least that some may change[43]. Professional organisation position statements can change over time and may not in themselves be scientific evidence.

28. **The MoU forbids "a therapeutic approach…which attempts to bring about a change of sexual orientation…, or seeks to supress an individual's expression of sexual orientation" [44] , as though "sexual orientation" were a stable or scientifically definable entity.** Large, representative studies in the U.K. and U.S. have found that it is the *exception* that individuals who have had same-sex sexuality experiences have experienced only and persistently all of the following: exclusive same-sex attraction, exclusive same-sex partners, and exclusive homosexual identity.[45] Further, same-sex attraction, behaviour, and identity commonly are not all present in the same person, may each be directed differently toward the same, both, or opposite sex, and may each change independently of the others within the same person and at different times from each other.[46] Sexuality experiences can be messy and may not necessarily fit a concept of an orientation.

29. **How does one, for example, coherently define "homosexual orientation"? A notable minority of men who identify as homosexual experience opposite-sex attraction and some experience opposite-sex relationships.**[47] What amount of same-sex attraction feelings define a homosexual orientation? Is it one moment of same-sex sexual attraction feeling in one's lifetime? A month, a year, perpetually lifelong? What if there are also opposite-sex attraction feelings one time, at times, ongoing to a small degree? Does there have to be same-sex behaviour? If so, how much? Once, sometimes, predominantly, exclusively? Do the degrees of attraction toward and sexual behaviour with the same sex need to match? What if attraction feelings or

[40] APA Task Force, 2009, pp. 63, 86.
[41] Tolman & Diamond, 2014, *APA Handbook of Sexuality and Psychology, vol. 1*, pp. 636, 562, 619; on p. xvi the APA declared its *Handbook* "authoritative" and gave the organisation's "imprimatur".
[42] American Psychiatric Association, 2019.
[43] Royal College of Psychiatrists (RCPych), 2014.
[44] Memorandum of Understanding, July 2024.
[45] Laumann et al., p. 299; Sullins & James, 2022, Table 2; Geary et al., 2018, pp. 10-11, Table 3, p. 5.
[46] Kaestle, 2019; Calatrava, Sullins, & James, 2023; may not be aligned: Wells, McGee, & Beautrais, 2011).
[47] Kaestle, 2019, p. 817.

behaviours change at different rates or times? What if same-sex feelings or behaviours occurred only in youth and never again[48], only beginning in mid- or late-life, only ever with one specific person, only after choosing same-sex preference for social or political reasons[49], or only when under distress?[50] Does the person have to adopt an "orientation" identity? Does an identity, if the person has one, need to match sexual attraction? Behaviour? Both? What if an "orientation" identity self-label changes independently of attraction or behaviour? Are some same-sex behaviours not part of a sexual orientation?

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

31. **Abundant, rigorous r*esearch* has established in the U.K. and internationally that same-sex attraction, behaviour, and identity commonly change through life experience.** Several studies were large (1,000 to more than 22,000 participants), population-based or cohort-based, and longitudinal studies (6 to 10 years).[51]

    a. **Both-sex attracted people commonly experience changes,[52] and, contrary to popular view, most same-sex attracted people by far are both-sex attracted.** The American Psychological Association's *APA Handbook of Sexuality and Psychology* says, based on research[53], "Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true: Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception."[54]

[48] Laumann et al., 1994, p. 296.
[49] Diamond, 2014, *APA Handbook*, Chapter 20.
[50] Byrd, Nicolosi, & Potts, 2008, p. 21.
[51] Dickson et al., 2003, Figure 1; Dickson et al., 2013, Table 4; Hu & Denier, 2023b; Hu, Xu, & Tornell, 2015; Kaestle, 2019; Mock & Eibach, 2012; Ott, Corliss, et al., 2011; Savin-Williams and Ream, 2007; Savin-Williams, Joyner, & Rieger, 2012.
[52] Savin-Williams, Joyner, & Reiger, 2012, Figure 1; Dickson et al., 2013, Table 4; Hu & Denier, 2023, Table 1.
[53] Savin-Williams, Joyner, & Reiger, 2012, Figure 8; Dickson, Paul, & Herbison, 2003, Figure 1; Dickson et al., 2013, Tables 1, 4.
[54] Diamond, 2014, in *APA Handbook, vol. 1*, p. 633.

b. **Adolescents have high rates of change found in population- and cohort-based studies.**[55]

c. **High rates of change to exclusively heterosexual attraction have been found in several large, longitudinal, population- or cohort-based studies.**[56]

32. Therapists, clients, and researchers should be able, in principle, to identify life experiences that are leading to these changes, especially for both-sex attracted individuals (most of whom are mostly heterosexual or bisexual, some of whom are mostly homosexual). In fact, we do have research evidence on some relational life experiences leading to these changes, as follows.

33. Research has substantiated that, in both the U.K. and the U.S., *most* individuals who experience both-sex sexuality and some who experience predominantly same-sex sexuality and who are in a relationship are in opposite-sex relationships.[57] Many individuals who identified as experiencing same-sex sexuality felt they had some "perceived *choice* about sexual orientation", where "choice" was not further defined, perhaps meaning choice in the sex of the person with whom they had a relationship.[58] **Satisfying opposite-sex relationships for those who feel they have a choice may lead to opposite-sex interest increase, same-sex interest decrease**[59], **and opposite-sex relationship satisfaction that is real, 80% satisfaction in one study**[60]**.**

34. There is evidence that being in an opposite-sex relationship, being a father, and being in a traditional religion or conservative culture may help some individuals decrease same-sex behaviour and attraction and increase opposite-sex behaviour and attraction through *therapy* that is open to such change. It is notable that *men who were fathers and men for whom same-sex behaviour is inconsistent with their values were particularly successful in reducing same-sex partners* according to studies by both LGB-identity-affirmative researchers and traditionally religious researchers. These studies were a randomised controlled trial conducted by LGB-identity-affirmative researchers of men who have sex with men[61] and studies of change-allowing therapy for mostly traditionally religious, commonly married, men[62].

35. Professional therapists and counsellors help people experience satisfaction in their relationships. As a result of the MoU, however, therapists will be afraid to risk assisting clients with these relationships and sexual attraction shifts for fear such assistance will be labelled as "conversion therapy" and lead to their being punished

[55] Laumann et al., 1994, p. 296; Savin-Williams & Ream, 2007 with Fish & Russell, 2018 answer to skeptics; Ott et al., 2011.
[56] Diamond & Rosky, 2016, p.7, Table 1; Savin-Williams et al., 2012; Dickson et al., 2013, Table 4.
[57] Heslin & Alfier, 2022, Tables 3 and 4; ONS, 2012 to 2020, Table 5b; Sullins, March 2024a; Hu & Denier, 2023b; 2023a, Table A4; Herek et al., 2010, Table 8; Kaestle, 2019, figure 3 and p. 819; Jones, 2022, pp. 5-6.
[58] Herek et al., 2010, p. 186, Table 3.
[59] Diamond, 2008, pp. 114-118; Diamond, 2014, Ch. 20, in *APA Handbook;* Pomeroy, 1972, pp. 76-77.
[60] Lefevor, Beckstead, et al., 2019, abstract.
[61] Nyamathi et al., 2017.
[62] Sullins & Rosik, 2024; Karten & Wade, p. 87; Byrd, Nicolosi, & Potts, 2008, pp. 7, 16-17, 20; Throckmorton & Welton, 2005, p. 11.

by their accrediting body. The MoU, in restraining this help for clients who desire it, often to protect their marriage and family, is unjustified and unethical.

VI. DISCORDANT GENDER IDENTITY MAY CHANGE THROUGHOUT THE LIFESPAN

36. **The UK Council for Psychotherapy has confirmed the MoU accepts affirmation of gender discordance at every age[63].**

37. **If not affirmed, gender dysphoria and discordant gender identity resolve for about 85% of children according to 11 out of 11 studies[64], up to 75% of adolescents[65], and adults at any age[66].**

38. **The seriously harmful result of affirmative interventions that can be expected is that many children and adolescents who otherwise would have resolved their gender discordance and lived comfortably in their bodies with reproductive health and fertility and greater general health will not do so.[67]** Children who are socially transitioned to dress and live as the opposite sex[68], and children who are given puberty blockers[69] are far less likely to resolve gender dysphoria.

39. **Yet even then, detransitioners are evidence that gender discordance may change at every age and even after bodies may have been permanently harmed by medical gender interventions.[70]**

VII. DISCORDANT GENDER IDENTITY MAY HAVE TREATABLE PSYCHOLOGICAL CAUSES

40. **There is a growing professional consensus that gender dysphoria may have treatable psychological causes and/or that the first line treatment should be psychotherapy, not body harming medical interventions.**

    a. **The final Cass report commissioned by NHS-England says research suggests that adverse childhood experiences (ACEs), mental ill health, and potentially sociocultural pressures associated with womanhood/femininity are predisposing factors to gender dysphoria.[71] It says consumption of adolescent pornography that often portrays an expectation that sex will be**

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[63] UKCP, April 2024.
[64] Singh, Bradley, & Zucker, 2021; Steensma et al., 2010, p. 500; Ristori & Steensma, 2016; research review: Zucker 2018; American Psychiatric Association, 2022, *DSM-5-TR*, 516; Cass, April 2024, p. 223.
[65] 75%: Rawee et al., 2014; 10% regret or detransition plus 20% discontinuation: Boyd et al., 2022, p. 13; 22%: Elkadi et al., 2023.
[66] Adults 36%: Roberts et al., 2022; American Psychiatric Association, 2022, p. 512 “transitory”; Zucker, Lawrence, & Kreukels, 2016, p. 237; Shaw et al., 2012, p. 25, “in midlife” and “later in life”.
[67] Zucker, 2018; 2019; American Psychiatric Association, 2022, 516; American Psychological Association, 2014, vol. 1, p. 744.
[68] Steensma et al., 2013; Olson et al., 2022.
[69] Few resolve gender dysphoria on puberty blockers: 3.5% in Brik et al., 2020; 2% in Carmichael et al., 2021; 1% in Kuper et al., 2020; 1.4% in van der Loos et al., 2023; 2% in Wiepjes et al., 2018.
[70] Vandenbussche, 2021; Littman, 2021.
[71] Cass, 2024: ACEs: 5:50; 8.40; mental ill health: 8.41-42; 11.5; sociocultural pressures: 7.18-19.

aggressive toward females may contribute.[72] It also says that treating mental health disorders that precede gender distress and strengthening the individual's sense of self may help to address the gender-related distress.[73]

b. **NHS-England[74] and health authorities of other governments are moving away from gender-affirmative treatment and toward prioritizing psychotherapy**—for example in Finland,[75] Sweden,[76] Denmark,[77] and at least 25 of the 50 U.S. states.[78]

c. **Some professional organisations have acknowledged the potential existence of pathological psychiatric causes for gender incongruence**—for example the American Psychiatric Association[79], World Professional Association for Transgender Health Standards of Care[80], British Psychological Society guidelines[81], and American Psychological Association[82].

41. A research review commissioned for the Cass review[83] and studies internationally have generally found an *association* between gender dysphoria and high rates of psychiatric conditions.[84] This association is widely accepted and not controversial.

a. Gender dysphoric children[85], adolescents[86], and adults[87] have evidenced mental health disorders to a degree that is strongly and significantly different from individuals who identify with their sex but no different from those who have clinical diagnoses other than gender dysphoria.

b. Many additional studies have found that incongruent gender identity, like same-sex sexuality, is associated with high rates of history for adverse childhood experiences.[88]

42. Most studies that show a high correlation between psychiatric conditions and gender discordance do not tell us which came first. Some of them, however, do, and all of which I am aware show that high rates of psychiatric disorders and adverse conditions largely come first. This finding suggests potentially treatable psychiatric

[72] Cass, 2024, 7.18-7.20 on p. 110; Hanson, 2020; Nadrowski, 2024.
[73] Cass, April 2024, 8.40-8.42, p. 119.
[74] Cass, Feb. 2022, pp. 20, 69; April 2024, p. 200.
[75] Finland: COHERE, 2020.
[76] Sweden: NBHW, 2 Feb. 2022. p. 2; SEGM, 27 Feb. 2022, p. 2.
[77] Denmark: SEGM, 17 August 2023; Løhde, 2023.
[78] At least 25 of the 50 U.S. states updated on a map: ACPeds, May 2024.
[79] Byne, 2012, p. 764.
[80] Coleman et al., 2012, version 7, p. 180; Coleman et al., 2022, version 8, p. S62, S71.
[81] Shaw et al., 2012, p. 26; British Psychological Society (BPS), 2019, p. 6, though it under-rates prevalence.
[82] Bockting, 2014, *APA Handbook* of *Sexuality and Psychology, vol. 1*, p. 743.
[83] Thompson et al., 2022, p. 41.
[84] Haynes, 2024, MoU Full Report at "VII. Discordant Gender Identity…Treatable Psychological Causes".
[85] Di Ceglie et al., 2002, commissioned research for the Cass review.
[86] de Vries, 2016, see p. 280; Thrower et al., 2020.
[87] Giovanardi et al., 2018.
[88] Cass review: Di Ceglie, 2024; Baams, 2018; systematic research review: Schneeberger et al., 2014.

conditions—serious psychiatric disorders, neurodevelopmental disabilities such as autism, self-injuring behaviour, suicidality, and trauma from adverse childhood experiences—may *predispose to or be causal for* gender discordance.[89]

43. **Under the MoU and threat of a legislative therapy ban in the UK, treating gender dysphoria by evaluating for and treating potentially predisposing serious psychiatric conditions has harmfully decreased. This is dangerous. Untreated psychiatric conditions are a known cause of suicides.** [90]

    a. **The Cass review reported that mental health practitioners in England have been afraid under the MoU and threats of a legal therapy ban, to evaluate gender dysphoric young people for co-occurring mental disorders and to treat these disorders the usual ways** for fear of being accused of conducting "conversion", rather than affirmative-only, therapy.[91]

    b. **Detransitioners want help for gender dysphoria and high rates of mental health problems that gender-affirming practitioners did not treat and affirmative medical transition did not resolve, but the MoU prohibits therapy to change how a person perceives their gender. Detransitioners report therapists are afraid to help them, and they cannot get help.[92]**

44. **Patients should be able to have the same kinds of psychotherapy to explore and resolve gender dysphoria and potential causes that therapists provide for patients who want to resolve diagnoses or disorders generally. There is no reason to call standard therapy "conversion therapy" when the disorder patients have a goal to resolve is gender dysphoria. The MoU is forbidding ordinary therapy.**

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

45. **The MoU uncritically accepts unproven treatments for gender dysphoria that can cause serious and permanent body harms and that do not improve mental health.**

    a. **The MoU accepts medical interventions that** sterilise, decrease ability to function sexually and to enjoy sexual pleasure [93], potentially remove or disfigure healthy organs, increase deaths from chronic diseases [94] are associated with persistence or worsening of psychiatric disorders according to

[89] Rated "5": "highest quality" in the Cass review commissioned systematic research review by Thompson et al., 2022, p. 6 key and Table 3: U.S.: Becerra-Culqui et al., 2018, and Finland: Kaltiala-Heino, et al., 2015. Bechard, et al., 2017, p. 681, Table 1 on p. 682; Australia: Kozlowska, McClure et al., 2021 with expanded discussion in Kozlowska, Chudleigh et al., 2021; Thrower et al., 2020, abstract.
[90] Cass, April 2024, 16.22, NBHW, 2020; Cavanagh et al., 2003.
[91] Cass, 2022, p. 47, 48; 2024, 17:20-23.
[92] Vandenbussche, 2021; Littman, 2021.
[93] Coleman et al., WPATH Standards of Care, 2022, pp. S102, S119, S167.
[94] Dhejne et al., 2011.

population registry studies internationally[95], even as psychiatric disorders are known to be associated with increased suicide rates[96], and have never been shown to be more effective than psychotherapy or psychiatric medications for gender dysphoria[97]. Yet the MoU accepts these body-altering interventions uncritically and opposes consensual psychotherapy or counselling conversations that do not conform to its approved viewpoint.

b. **Systematic reviews of the "Dutch studies" that have served as the foundational research evidence for the safety and effectiveness of gender-affirming treatment for minors[98] have been rated by NHS-England as "very poor certainty"[99]** and have been found to have multiple invalidating flaws[100]. Research at the Tavistock that attempted to repeat the Dutch study did not replicate its positive findings.[101]

46. **An MoU approved affirmative approach can cause serious psychological harm, as explained by Evans and Evans.** Marcus Evans is an author and psychoanalyst who was clinical lead of the Adult and Adolescent Departments at the Tavistock and Portman NHS Foundation Trust for several years, and Susan Evans is an author and psychoanalytic psychotherapist who worked in the national gender identity service (GIDS) for children. [102] Evans and Evans hypothesise that gender dysphoria or incongruence is pathological and affirmation is dangerous. They say feelings of anger and grieving over body losses and failure of medical intervention to resolve serious mental health problems can lead to increased self-injury and suicidality. Transition may offer avoidance of normal anxiety about sexual development, but "over time, the adolescent can be helped and supported to become an adult who might enjoy what their natal sexual body has to offer."[103] Children demanding transition may wish their parents would understand them instead of supporting transition. They may be disappointed professionals were unable to stand up to their demands. The wish to transition may be expressing grievances toward parents. The path to psychological maturity and mental health requires tolerating aspects of oneself, not intolerance. Patients may fear the idea of an underlying context to gender dysphoria. Children's identities develop and change over time as they mature. Diagnoses made in childhood change on the path to adulthood. Patients need protection from rigid affirmation.[104]

47. **Evans and Evans charge the MoU with having been captured by a psychologically shallow political agenda.** "This Memorandum implies that there is a fixed category called 'transgender' which, like eye colour, is simply a given that need not be thought

[95] Denmark: Glintborg et al., 2023; U.S. Military: Hisle-Gorman et al., 2021; Finland: Kaltiala, Holttinen, & Tuisku, 2023; Sweden: Dhejne et al., 2011; Sweden**:** Banstrom & Pachankis, 2020a.
[96] Sweden: NBHW, 2020; Worldwide: Cavanagh et al., 2003.
[97] Cantor, 2022, pp. 3, 11-15**.**
[98] de Vries et al., 2011, de Vries et al., 2014.
[99] NICE, 2020a; 2020b; NHS CPAG, 2024.
[100] Abbruzzese, Levine, & Mason, 2023.
[101] Costa et al., 2015; Carmichael et al., 2021; McPherson & Freedman, 2023.
[102] Evans & Evans, 2021a; 2021b; M. Evans, 2020; 2023.
[103] Evans & Evans, 2021a, pp. 7-8.
[104] Evans & Evans, 2021a, pp. 10, 12,13.

about or understood. Children's *sexual orientation* and *gender identity* are formed out of a complex developmental process that involves an interaction between their body, their mind and society at large. Sexual identity and gender identity are developmental processes that evolve as the individual goes through the different life stages. The Memorandum is, in my view, symptomatic of the way that *political agendas* have influenced this area of clinical practice."[105]

48. **The MoU affirmative approach is not multiculturally appropriate. It can be seriously harmful for people of traditional religions and can even lead to suicidality[106], whereas religiously supportive therapy or ministry can reduce distress and improve mental health[107].** Change-allowing therapy that is open to a distressed client's goal of sexual self-acceptance is culturally appropriate for clients who desire to live consistently with their orthodox religion and become comfortable with their sex. This client-centred exploration should be accepted clinical practice. The Association of Christian Psychologists in Poland has developed an appropriate standard of care for this religious population.[108]

49. **The MoU uncritically accepts unproven gender-identity-affirmative interventions that can be harmful physically, psychologically, and multiculturally. The MoU does not have sound research evidence or professional consensus to justify enforcing an affirmative-only treatment approach or to withhold from gender distressed people psychotherapy they may want to experience more sexual self-acceptance.**

IX. ETHICAL GUIDELINES SUPPORT THE SAFETY AND EFFECTIVENESS OF CHANGE-ALLOWING PSYCHOTHERAPY

50. **A fundamental ethical premise is the right to self-determination which therefore must include the right to shape and develop one's own sexual identity, feelings and associated behaviours and to receive support to do so.**[109]

51. **Ethical change-allowing psychotherapists and counsellors follow ethical guidelines.[110]** They work to reduce shame which helps allow for change to occur naturally. They do not use aversive methods, guarantee therapy outcomes, take a position that a client *should* change sexuality or gender identity, or coerce a therapy goal, even if parents or spouse so desire. Change-allowing therapy is client-centred.

52. **Therapists plan individualised care collaboratively with clients** based on the best available evidence and the client's preferences, values, and beliefs.[111]

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[105] Evans & Evans, 2020, p. 2, emphasis added.
[106] IFTCC, 2024; Throckmorton & Wells, 2005; British Board of Scholars and Imams et al., 8 March 2024.
[107] Pela & Sutton, 2021; Jones & Yarhouse, 2011; Sullins & Rosik, 2024.
[108] Marianowicz-Szczygieł et al., 2024.
[109] IFTCC Practice and Ethics Guideline/PEG, 2023.
[110] IFTCC Practise and Ethical Guidelines (PEG), 2023; Alliance Guidelines, 2017; Reintegrative Standards, 2017.
[111] Cass, April 2024, 10.74-10.75 on p. 146; APA, Professional Practice Guidelines, 2021c.

X. THE BEST AVAIILABLE RESEARCH SUPPORTS THAT CHANGE-ALLOWING PSYCHOTHERAPY FOR SAME-SEX SEXUALITY IS SAFE AND EFFECTIVE

53. **The best available research has found that mental health improves in change-allowing therapy. Sexual *attractions* have changed as a by-product of psychological interventions in 1 counterbalanced experiment, 2 randomized controlled trials, and 3 longitudinal studies. While more research is needed, it is not possible to assert an incontrovertible generalisation that psychological interventions that may reduce or change sexual attraction are harmful or ineffective.**

    a. **British and Canadian researchers found in a counterbalanced experiment that even positive and enjoyable sexual fantasies became less vivid, positive, and arousing after a psychological intervention** (eye movement desensitisation reprocessing), whether the fantasies were based on memory or imagination **and apparently regardless of sexuality identity.**[112]

    b. **A randomised placebo-controlled trial found that 3 psychological interventions each reduced simultaneously 2 unwanted sexually arousing memories, decreasing their arousal, vividness, and emotionality. "Memories that participants reported were 69% unwanted same-sex memories, 25% unwanted heterosexual memories, and 6% unwanted bisexual memories** (1 same-sex and 1 opposite-sex)." "Other motivations for participating in this study included to counter temptation to return to extra-marital sexual activities, to address attraction to underage individuals, to eliminate pleasurable associations to a trusted caregiver who subsequently abused, and to reduce sexually arousing memories no longer desired by a detransitioner." Regarding recruitment of the 144 participants, "Nearly one-third of the participants found the study through the Muslim podcast, another one-third through the married Christian podcast, and the final one-third through Reddit and UCLA [University of California at Los Angeles] on-campus recruitment." [113]

    c. **In a multi-methods, randomized, controlled experiment with women of mostly heterosexual attraction, considered a study of gold standard research design,** researchers studied potential sexual attraction change as a by-product of mindful attention. **The researchers expected the women's opposite-sex attraction to increase, which it did, and their same-sex attraction to increase, but it decreased.** Participants' self-reports of subjective arousal or distraction mirrored their neural activity observed in fMRI data. Since neither researchers nor participants had a goal or even expectation that same-sex attraction would decrease, they did not have a preconception that would have biased them to perceive this outcome falsely.[114]

[112] Bartels et al., 2018.
[113] Nicolosi & Szandula, 2025 in press, abstract.
[114] Dickenson & Diamond, 2018; Dickenson et al., 2020.

d. Mental health improved, opposite-sex attraction and behaviour increased, and same-sex attraction and behaviour decreased in 3 prospective, longitudinal studies of mostly religious participants who had these changes as a goal. Two of these studies were independent, quantitative, prospective, longitudinal, quasi-experimental, naturalistic, repeated measures studies that measured same-sex and opposite-sex attractions separately and met many of the standards proposed by the American Psychological Association Task Force[115] but did not have a comparison group.

i. One of the quasi-experimental studies found that men in professional psychotherapy with therapists certified in Reintegrative Therapy® improved psychological well-being significantly, clinically, and strongly. They also significantly decreased same-sex attraction expressions, increased opposite-sex attraction expressions, and changed sexual attraction identity in the heterosexual direction. It appears that most participants (71%) ended their therapy after completing at least 12 months but less than 18 months of therapy.[116] Reintegrative Therapy® uses a specific combination of evidence-based mainstream interventions for trauma and addictions and includes mindful self-compassion.[117]

ii. The other quasi-experimental study found psychological symptoms only improved for men and women participants in religiously mediated change efforts through a religious support organization. Overall, 53% came to categorize as some version of success. Specifically, 23% reported opposite-sex attraction substantially increased and same-sex attraction substantially decreased, and an additional 30% reported they only experienced same-sex attraction incidentally, "allowing them to live contentedly without overt sexual activity." Since most changes occurred in the first year or two and persisted over the 6 to 7 years of the study, this was in effect a follow-up study.[118]

iii. An early and less rigorous longitudinal study found sexuality changes were associated with better mental health. Opposite sex attraction increased, and abstinence was achieved over one year of follow-up by 71% of participants who had been active in a religious support organization or who had experienced 38 therapy sessions (about 9 months if meeting once a week) or more. The study included men and women.[119] The modest aim of both religious longitudinal studies was to find out whether change *ever* occurred through religious-mediated change efforts. They concluded it did.

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[115] Jones & Yarhouse, 2011, p. 406; APA Task Force, 2009, p. 6.
[116] Pela & Sutton, 2021, therapy length for most participants inferred from Table 3.
[117] Pela & Sutton, 2021; https://www.reintegrativetherapy.com.
[118] Jones & Yarhouse, 2011; the APA task force, 2009, did not have access to the final outcomes of this study.
[119] Schaeffer, et al., 2000, 1999.

54. **There is notable evidence that one of the most common goals of change allowing therapy, namely to reduce ("suppress" in the MoU) same-sex partners or behaviour, was achieved through 4 randomized controlled trials culturally sensitive to men who have sex with men**[120], **3 longitudinal studies culturally sensitive to traditionally religious people reported above,** [121] **and additional studies described in the full expert report**[122]. In the largest of the LGB-identity sensitive, randomised, controlled trials and in traditional religion sensitive studies, men who were married and/or were fathers and may have desired to protect their marriage and family and men who preferred to live consistently with traditional values (they had high "homonegativity" or were highly religious) were especially successful at decreasing same-sex partners.[123]

55. **The MoU prohibition against client-centred therapy**—that decreases distress and that for some successfully decreases same sex behaviour or attraction or increases opposite-sex attraction and behaviour—**based on a viewpoint is discriminatory and does not have incontrovertible scientific evidence to justify it.**

XI. EMERGING RESEARCH SUPPORTS THE SAFETY AND EFFECTIVENESS OF INCREASINGLY NEEDED CHANGE-ALLOWING PSYCHOTHERAPY FOR GENDER DYSPHORIA

56. **There is an ongoing and growing need for professional therapy and counselling the MoU appears to forbid for resolving gender dysphoria as England and Wales**[124]**—along with health authorities in other areas of the world—are moving away from the affirmative medical approach and toward psychosocial treatment.**

    a. **Some gender dysphoric people may want or need a non-medical alternative option for a variety of reasons,** such as medical problems that rule out medical gender interventions or that may become worse after such treatments[125], mental health problems that foreclose capacity to consent to medical gender treatments[126], physical appearance features that will hinder being able to pass as another sex, desire to save ones marriage and family[127], and desire to live consistently with religious preferences, values, and beliefs.

    b. **Psychosocial care for detransitioners**[128] is recommended by the Cass report, the WPATH standards of care, and Finland's government.[129]

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[120] Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Nyamathi et al., 2017.
[121] Pela & Sutton, 2020; Jones & Yarhouse, 2011; Schaeffer et al., 2000; 1999.
[122] Haynes, 2024b, at "The Best Available Research…Psychotherapy for Same-Sex Sexuality…."
[123] Nyamathi et al., 2017; Sullins & Rosik, 2024.
[124] Cass, April 2024.
[125] Lupron, 2023; Biggs 2019a; 2019b; Wiepjes et al., 2020; Brik et al., 2020; Anacker et al., 2021; Laidlaw & Jorgenson, 2024.
[126] Coleman et al., 2022, WPATH SOC Version 8, Statement 18.1 on p. S172.
[127] Zucker, Lawrence, & Kreukels, 2016, p. 237.
[128] Vandenbussche, 2021; Littman 2021.
[129] Cass, April 2024, p. 155, COHERE Recommendation 25 on p. 43; Coleman et al., 2022, recommendation 5.7 on p. S32, Statement 5.7 on pp. S41-S42; COHERE Recommendation, section 9 calls for research.

c. **Ethically, therapists should advise gender dysphoric patients of treatment risks and alternatives. Solely offering affirmative interventions is resulting in lawsuits** and hence now poses risk to therapists as well as clients.[130]

57. **There is a great need to increase the knowledge base of psychotherapy for reducing gender dysphoria, and the NHS-England has committed to conducting research into it[131].** It may now be expected or hoped that countries that prioritise and support psychotherapy for treating gender dysphoria will build a repertoire of clinical experience and research into such therapy.

58. **There is no consistent evidence that medical gender interventions improve psychological functioning better than psychotherapy, as has been previously discussed,[132] and there is emerging evidence in support of effectiveness of psychotherapy for decreasing gender discordance or incongruence.**

a. **The Cass report says therapies that are well-proven for mental health problems associated with gender dysphoria might also treat core gender dysphoria** and research should look at this.[133]

b. **Psychotherapy treatments already exist for trauma and psychiatric conditions known to pre-exist and potentially predispose to or cause gender dysphoria. Finland's Recommendation calls for first line psychotherapy to treat psychiatric disorders that may predispose a young person to gender dysphoria.[134]** These psychiatric conditions are generally not treated by puberty blockers, cross-sex hormones, or sex surgeries.

c. **There is evidence that gender dysphoria has decreased in young people who** (1) received psychosocial support for other mental health problems while they had childhood gender dysphoria[135], (2) received psychiatric or psychological treatment *with* gender medical interventions[136], or (3) received psychosocial or psychiatric support *without* gender medical interventions[137].

d. **A university medical centre gender clinic cohort study in Germany found relationships with families and peers, not affirmative social transitioning or**

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[130] RANZCP, 2023; Exposito-Campos, 2021; Beckford, 2022; Chloe Cole vs. Kaiser-Permanente, 2023; Hammer, 2023; Campbell et al., 2023.
[131] Cass Report, 2024, examples Recommendations on pages 35, 39, 41, 44. NHS England, 10 April 2024, NHS response.
[132] Elkadi et al., 2023; Dhejne et al.,2011; Branstrom & Pachankis, 2020a; 2020b; Costa et al., 2015; Zucker, 2018; Exposito-Campos, 2021, p. 274; Cantor, 2022, p. 3.
[133] Cass, 10 April 2023, p. 150.
[134] COHERE, 2020.
[135]Kosky, 1987; Cantor, 2022, pp. 6-7; some desistance studies appear to support this: Singh et al., 2021; Davenport, 1986, reported several publications of successful treatments; Wallien & Cohen-Kettenis, 2008.
[136] Cantor, 2022, p. 11.
[137] Carmichael et al., 2021; Costa et al., 2015; McPherson & Freedman, 2023; Smith, Goozen, & Cohen-Kettinis, 2001, p. 479; COHERE, 2020 accepts Costa et al., 2015.

parents support for it, accounted for the mental health of gender dysphoric children. The clinic offered psychoanalytic individual and family therapy.[138]

e. **It may be that psychotherapy tends to facilitate resolution of childhood gender dysphoria even when there is not a therapist or patient intent toward such resolution, as in some childhood desistence studies. Offering psychotherapy may in effect be offering change-allowing therapy.[139]**

f. **Since some detransitioners reportedly can resolve gender dysphoria or mental health problems through personal insight-oriented exploration[140], it seems plausible they should be able to do so with professional assistance.**

g. **There are case reports supporting that psychotherapy has successfully helped people either to *decrease* gender distress without resolving it[141] or to *resolve* gender distress[142]. *Affirmative* medical treatments—uniquely among psychiatric or psychological treatments—affirm people in their diagnosis.**

h. **At present, case studies constitute some the best available research for psychotherapy to resolve gender dysphoria[143].**

59. **Some of the leading research on treating gender dysphoria comes from Dr. Kenneth Zucker, a clinician, researcher, academic, and advocate for a client's right to choose a psychotherapy goal to resolve gender dysphoria.**

a. **Dr. Zucker was the Chair of the Work Group on Sexual and Gender Identity Disorders for the American Psychiatric Association's official diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (2013). This manual has been used worldwide by clinicians and researchers to diagnose gender dysphoria and was the most used by European gender services studied for the Cass report.[144]**

b. **In the therapy model of Kenneth Zucker and colleagues, *the treatment goal* is to "have the child feel more comfortable in their own skin", that is, "to reduce the child's desire to be of the other gender".[145]** Cross-sex identity expression is seen as a symptom that may develop from an interplay of influences such as a child's atypical temperament, permissive parent response to cross dressing, a child's immature understanding of the concept of gender,

[138] Sievert et al., 2021.
[139] Desistance studies examples: Singh et al., 2021; Davenport, 1986, reported several publications of successful treatments; Wallien & Cohen-Kettenis, 2008. Case example evidence of this in Ayad et al., 2022.
[140] Vandenbussche, 2021; Littman, 2021.
[141] Example: the cognitive-behavioural therapy approach of Canvin, Hawthorne, & Panting, 2022.
[142] As will be discussed. Example: Zucker et al., 2012.
[143] Examples: Zucker et al., 2012; also: Bradley & Zucker, 1990; 1997; Evans & Evans, 2021b; Kosky, 1987; Lim & Bottomley, 1983; Zucker 2001; 2004; 2006; Zucker & Bradley, 1995; 2005.
[144] Hall et al., 2024, Gender Services, p. 5.
[145] Zucker, Wood, Singh, & Bradley, 2012, p. 383, see p. 388.

co-occurring psychopathology, and trauma or conflict that gets transferred from a parent to the child.[146]

c. **Dr. Zucker was the Psychologist-in-Chief at Toronto's Centre for Addiction and Mental Health (CAMH) Gender Identity Service** from 1981 to 2015. In 2015, Zucker was ousted from the CAMH under allegations that CAMH later acknowledged proved to be false. CAMH apologised without reservations and paid him a settlement of over half a million dollars.[147]

c. **Dr. Zucker continues to this day to be the editor-in-chief of the eminent, peer-reviewed, professional journal, *Archives of Sexual Behavior*.[148]**

d. **At universities in Canada that are among the world's highest ranked, the University of Toronto, 1978-2017 and York University, 1985-2015[149], Zucker *taught* courses on psychopathology of childhood and *specifically taught courses titled "Psychosexual Differentiation and Its Disorders" and "Seminar on Gender Dysphoria, Behavioral Disorders in Children"*.**

e. **Research evidence supports the effectiveness of clinical care Dr. Zucker advocated for and taught**. In an area of still emerging research, case studies may be the best available evidence. Zucker and others have published a reasonable number of case studies of successful treatment[150] and a study finding that 88% of boys who were evaluated at the clinic Zucker led and who, if they received treatment, received his approach to care, came to identify with their sex.[151]

f. **Dr. Zucker *advocated* for a client's right to request "a psychotherapist's help in trying to make their gender identity and gender expression more congruent with their assigned sex…"** as a matter of "the client's right to autonomy and self-determination.". [152]

g. **Thus, as a leading researcher, academic, clinical psychologist [153], and recognized world authority on gender dysphoria, *he advocated for[154] and taught* psychotherapy to *resolve* gender dysphoria, that the MoU forbids, in publications of the American Psychiatric Association and at leading universities in Canada.**

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[146] Zucker et al., 2012.
[147] "CAMH reaches settlement", 2018.
[148] Kearns, 2018.
[149] University of Toronto, Canada, 1978-2017: U.S. News and World Report, retrieved 3 October 2024; York University, Canada, 1985-2015: Times Higher Education World University rankings, 2024.
[150] Examples: Bradley & Zucker, 1990; Lim & Bottomley, 1983; Zucker, 1985; 2001; 2004; 2006; Zucker & Bradley, 1995; 2005.
[151] Singh et al., 2021, p. 4.
[152] Zucker, Lawrence, & Kreukels, 2016, p. 237.
[153] Zucker, 2020, extensive curriculum vita.
[154] Zucker, Lawrence, & Kreukels, 2016, p. 237.

60. Should the therapy goal of helping individuals resolve gender distress, become comfortable identifying with their naturally sexed body, and enjoy what it has to offer be banned as "conversion therapy"?

a. The Cass report said,

> **11.5** Whilst the Review's terms of reference do not include consideration of the proposed legislation to ban conversion practices, it believes that no LGBTQ+ group should be subjected to conversion practice. It also maintains the position that children and young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. **Exploration of these issues is essential to provide diagnosis, clinical support and appropriate intervention.**
>
> **11.6** The **intent** of psychological intervention **is not to change the person's perception of who they are** but to work with them to explore their concerns and experiences and help alleviate their distress, regardless of whether they pursue a medical pathway or not. **It is harmful to equate this approach to conversion therapy** as it may prevent young people from getting the emotional support they deserve.
>
> **"11.7 No formal science-based training in psychotherapy, psychology or psychiatry teaches or advocates conversion therapy**. If an individual were to carry out such practices they would be acting outside of professional guidance, and this would be a matter for the relevant regulator."[155]

b. Whatever this passage means by "conversion therapy," the statement in the passage is not true of therapy that has an "intent" to "change the person's perception of who they are". Zucker, a recognised world authority on gender dysphoria, *both taught psychiatrists and psychologists and advocated* for therapy that has an intent to change how a person perceives their gender identity, and case studies and follow-up research of boys referred to his clinic lend support that it was effective.

c. The Cass Report also said, "an individualized care plan" should be "based both on evidence, and the person's individual preferences, beliefs and values".[156] This appears to mean—and does not appear to rule out—that therapy with the intent of reducing gender distress may be based on a person's preferences, beliefs and values to become able to identify comfortably with their sex, for example in order to preserve their marriage and family or to live consistently with their religion.

d. In this case, the therapy may be thought of as *exploratory psychotherapy that is open to a client's preference to explore potential to become*

[155] Cass, April 2024, pp. 150-151.
[156] Cass, April 2024, 10.74-10.75 on p. 146.

comfortable with their sexed body. The point of the *therapist* not predetermining a therapy outcome goal is to respect *the client's self-determination.* But can clients have a predetermined goal for their own therapy? If a boy says to a therapist, "My grandmother dressed me in a purple dress, I felt loved as a girl, never as a boy, and my uncle sexually molested me.[157] Will you help me explore these and see if I can become happy being a boy?" the therapist should be able to aid in that client's desired exploration.

e. Therapists who work by exploring the context in which gender discordance emerged include therapists who practice exploratory therapy[158], which the Cass report recommends[159], developmental psychologists like Zucker and colleagues[160], psychoanalytically-oriented therapists like Evans and Evans[161], and change-allowing therapists [162] . Presumably all of these come to a collaborative agreement with the client on the goal of the therapy.

61. To be clear, the MoU forbids psychotherapy that has been conducted, formally taught to train psychiatrists and other mental health professionals, advocated, and supported by the best available evidence—case studies and relevant research—by this leading world authority, Kenneth Zucker, and colleagues that has the intent to change how a person perceives who they are based on preferences, beliefs, and values—that is, based on *viewpoints*—that favor helping a person be comfortable with and identify with their sex. Therapy that has this goal should be considered legitimate clinical work. The MoU prohibition of this therapy goal does not have professional consensus in support of it.

MEETING CHALLENGES TO CHANGE ALLOWING THERAPY

XII. CHALLENGES TO CHANGE-ALLOWING PSYCHOTHERAPY

62. The often-misrepresented Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation ("APA Report")[163] originated the term "sexual orientation change efforts" ("SOCE"). It distinguished contemporary SOCE that is psychoanalytically oriented, for which it said it had no research evidence that it was ineffective or harmful[164], from aversive methods it said were abandoned about 40 to 50 years ago—since about the 1970's, or early 1980's[165]. It evaluated aversive methods at length, even as it said contemporary therapists do not use them, possibly confusing readers as to their relevance today.

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[157] Heyer, 2014.
[158] NHS-England, 2022; UK Council for Psychotherapy (UKCP), 2023; Ayad et al., 2022, clinical guide of GETA.
[159] Cass, April 2024, p. 150, 11.5.
[160] Zucker et al, 2012.
[161] Evans 2020; 2023; Evans & Evans, 2021a; 2021b.
[162] IFTCC, PEG, 2023; Marianowicz-Szczygieł et al., 2024., ACPP standards and guideline appropriate for patients of traditional Christian religion.
[163] APA Report, 2009.
[164] APA Repot, 2009, p. 42.
[165] APA, Report, 2009, pp. 22, 82.

63. **The APA Report found no research that met its scientific standards[166], and none exists to this day, that shows (1) contemporary change-allowing therapy is harmful[167], ineffective[168], or leads to suicide for adults or minors, (2) same-sex attraction is not changed through life events[169]**, (3) LGB-identity-affirmative therapy is safe, effective, affirmative, or ethical for the subpopulation that regards religious identity, and not LGB identity, as its identity and does not consent to affirmative therapy, (4) identity exploration therapy is relevant for a same-sex attracted population that does not subscribe to taking a sexuality identity, and (5) LGB-identity-affirming therapy is better for non-LGB-identity-affirming clients than therapy that aligns with their preferences, values, and beliefs.

64. **The APA Report failed to mention that the research behind its claim that same-sex attraction is not caused by trauma or family dysfunction[170] also did not meet its own scientific standards to which it held SOCE[171]**. Population-based research, much of it published since the APA Report, contradicts its claim. Five years after the APA Report, the *APA Handbook of Sexuality and Psychology* acknowledged that childhood sexual abuse has "potentially causal links" to same-sex sexuality, based on research it praised for its rigour[172]. Several population-based studies have found higher rates of adverse childhood experiences and family dysfunction and instability are *associatively* linked to experiencing same-sex sexuality[173]. These alone do not prove causation but raise the possibility. There are also several prospective, longitudinal, controlled, cohort-based studies that have found that psychological distress, risky behaviour, adverse childhood experiences, and family dysfunction and instability, including absence or loss of a parent, especially the parent of the same sex as the child, are potentially *causally* linked to same-sex sexuality. These findings have come from the U.K., Finland, the U.S., and New Zealand. [174] Gender nonconformity in children who may or may not later experience same-sex attraction may lead to abuse by some unstable parents. It is unlikely, however, to cause of all these adverse experiences. Gender nonconformity does not equal same-sex attraction or inevitably lead to it. Not all children who come to experience same-sex sexuality and who were exposed to adverse childhood experiences evidence gender nonconformity [175]. It is also possible that adverse experiences may predispose some children to feel more safe or valued presenting more like or actually identifying as another sex.

[166] APA Report, 2009, p. 42. Standards: p. 90.
[167] APA Report, 2009, p. 42.
[168] APA Report, 2009, p. 43.
[169] APA Report, 2009, pp. 63, 86, see also 2, 54, 77.
[170] APA Report, 2009, p. 23.
[171] Rosik, 2012a.
[172] Mustanski, Kuper, & Greene, 2014, in *APA Handbook*, *vol. 1*, pp. 609-610; Wilson & Widom, 2010.
[173] Blosnich & Andersen, 2015, Brown et al., 2015, Corliss et al., 2002; Trans, Henkhaus, & Gonzales, 2022; Wells, McGee, & Beautrais, 2011.
[174] Oginni, Lim, Purves, et al., 2022; Oginni, Lim, Rahmen, et al., 2023; Zietsch et al., 2012; Fergusson et al., 1999; Udry & Chantala, 2005 and Francis, 2008 with Fish & Russell, 2018 support for their data set.
[175] Baams, 2018.

65. **A high court in the U.S. in Oct. 2020, found the APA's scientific case against SOCE to be weak. This circuit court struck down therapy bans in its jurisdiction.**[176]

66. **The American Psychological Association, while it has opposed change-allowing therapy as directed by its LGBT-identity-based division that excludes non-LGBT-identified people from decision-making, has not declared SOCE violates its ethics code.** I have been a member of the APA over 40 years. Neither I nor my colleagues who have offered change-allowing therapy have ever been charged by the APA with being unethical or had our licences revoked by our state governments. We have submitted critiques of proposed APA resolutions on SOCE to the committees that author them and been personally thanked for our thoroughness.[177]

67. **The APA Report [178], the British Psychological Society [179], and the British Association for Counselling & Psychotherapy [180] accepted affirmative therapy that they acknowledged lacked any research that met scientific standards to show safety or effectiveness. Any claim they might make that they oppose change-allowing therapy for supposedly lacking such evidence would appear to be disingenuous and biased.**

68. **Several randomised control trials, considered gold standard research, have found that LGB-identity-affirmative therapy that adapts standard therapy to gay culture was generally not more effective than standard therapy. Also in these studies, therapy that treated minority stress as a cause of mental health disparities in LGB-identified people was not more effective than not having the therapy.[181]**

69. **The National LGBT 2017 Survey commissioned by the U.K. Government Equalities Office is often referenced in support of a therapy ban.[182]**

    a. **They surveyed only people who took an LGBT identity, a common practice in surveys oppositional to change-allowing therapy.[183] Hence, they only survey people who have not changed (they still identify as LGBT). Since most people who experience same-sex attraction or behaviour do not take a sexuality identity, these surveys omit many of them[184] and may overrepresent people who hold the researchers' preferred LGBT-identity-affirmative cultural viewpoint and underrepresent people who do not share it[185]. A secondary**

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[176] Otto et al. v. City of Boca Raton, Florida et al., Nov. 20, 2020, p. 20, footnotes 7-8.
[177] Example: Haynes, L., 2023; Haynes & Rosik, 2023.
[178] APA, 2009, pp. 91.
[179] Shaw et al., 2012, pp. 71, 35.
[180] King et al., 2007, pp. 2-3, said no research they reviewed for *any* therapy for LGBT identified people met scientific standards; did not appear to include any research for non-LGBT-identified people who desired change-allowing therapy.
[181] Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; Pachankis et al., 2015; Nyamathi et al., 2017; Pachankis et al., 2020; Pachankis et al., 2022.
[182] GEO, July 2018 Summary Report; Research Report.
[183] Rosik, 2022.
[184] Laumann et al., 1994 p. 299; Geary et al., 2018, pp. 10-11, Table 3, p. 5.
[185] Rosik, Lefevor, Beckstead., 2021a, pp. 195-196, 198; Shaw et al., 2012, pp. 19-20.

analysis of the survey's data points out that the survey report would inappropriately apply viewpoints of exclusively same-sex attracted, single, non-religious, White people to both-sex attracted people, ethnic groups, and adherents of the major religions of the world and in the U.K. and who are the majority of people who would be targeted by a therapy ban.[186]

b. **The survey summary report said, "We did not provide a definition of conversion therapy in the survey".[187] As a result, we do not know what the survey studied. Most of the options participants could select to indicate who gave them "conversion therapy" are not therapists at all. They are family members and people of the major religions of the world.**

c. **Respondents were not asked whether "conversion" therapy was helpful or harmful in any way. Therefore, the value of this survey in guiding a decision about access to professional or pastoral counselling is significantly limited.**

d. **Muslims and Hindus would be the religious groups most affected by a therapy ban in the U.K.[188] The British Board of Scholars & Imams, the Muslim Council of Scotland (SCIO), & the Muslim Council of Wales have published online a critical evaluation of therapy bans proposed in their regions.[189] The international Organization of Islamic Cooperation (OIC) said,** "We believe that the concepts of sexual orientation and gender identity are not recognized under any international instruments, and run counter to the values and teachings of many religions and beliefs including Islam."[190] The OIC has 57 nation members and is the largest organisation of nations in the world next to the United Nations. The OIC "is the collective voice of the Muslim world."[191]

70. **The Ozanne Foundation 2018 Faith & Sexuality Survey[192] was strongly opposed to change-allowing therapy. Nevertheless, the authors acknowledged with surprise that participants who identified as "SSA" ("same-sex attracted", often used by people of traditional religious faiths who do not take an LGB identity) scored higher than all other groups on "Satisfaction with Spiritual Life". It appears that, rather than being driven to harms such as self-hate by their religious beliefs, they were the most spiritually flourishing.[193] The survey was hardly a study of people who experienced professional change-allowing therapy or counselling as youths[194] or even at all, as only 2.7% to 4.9% actually sought advice from NHS or**

[186] Sullins, 16 March 2024.
[187] GEO, July 2018, Summary Report, p. 14.
[188] Geo, July 2018, Research Report, p. 88; Sullins, 16 March 2024.
[189] British Board of Scholars and Imams et al., 8 March 2024.
[190] OIC, 2016, p. 68.
[191] OIC, History, no date.
[192] Ozanne, 2018.
[193] Ozanne, 2018, pp. 5, 19.
[194] IFTCC et al., 2018, critique of Ozanne, pp. 24, 28.

private medical professionals.[195] Overall, the survey was remarkably biased, poorly constructed, and often uninterpretable.[196]

71. **Other polls have found considerably more positive opinions** relative to therapy conversations to reduce same-sex attraction including a UK representative poll that found "64% of respondents said talking therapy to reduce SSA and keep a family together should be allowed"[197], a significant UK poll that found a therapy ban was not a priority for 96% of voters[198], and a Canadian nationally representative poll that found 91% support sexuality counselling choice[199].

72. **Contrary to a common misunderstanding, the United Nations has never passed a binding treaty in opposition to change-allowing therapy** and has never considered action on a report promoting such opposition by a volunteer "independent expert" individual to the Human Rights Council [200] or a report of an HRC high commissioner.[201] Many U.N. member states have rejected an expert's mandate.[202]

XIII. RESEARCH THAT CLAIMS CHANGE-ALLOWING THERAPY IS HARMFUL IS FATALLY FLAWED

73. **Opposition to change-allowing therapy has focused largely on claims of harm. There is, however, no research that meets scientific standards that substantiates disproportionate harm** from professional, noncoercive, nonaversive, client-initiated and client-directed therapy conversations using evidence-based methods and well-established practices therapists use around the world. **Studies claiming to have found disproportionate harm have employed biased methods.**[203]

74. **Studies that claim harm invalidly infer that an association between two things can tell us which one caused the other. This is called the "fallacy of association". In the first nationally representative study to claim harm from "sexual orientation change efforts" ("SOCE"),** Blosnich and colleagues[204] reported that LGB-identified people who had experienced SOCE from a religious leader (81%) or mental health care provider (31%) had experienced more suicidality in their lifetime than LGB-identified people who had not experienced SOCE. They employed the fallacy of association, meaning they invalidly inferred from an association between SOCE and suicidality that they could know one of them caused the other. They blamed SOCE and called for banning it.

75. **In contradiction to their claim, however, suicidality was higher before SOCE and lower after SOCE, therefore SOCE did not increase suicidality but rather SOCE**

[195] IFTCC et al., 2018, critique of Ozanne, p. 22.
[196] As detailed in the IFTCC et al., 2018, critique of Ozanne summarized in the Haynes, 2024b full report.
[197] ComRes, 2014.
[198] Christian Institute, 2023.
[199] Nanos, 2021.
[200] OHCHR, 8 July 2020.
[201] UN HRC, 2015.
[202] Example of 57 nations: OIC/CFM-43, 2016, p. 68; see OIC, n.d.
[203] Rosik, 2020a.
[204] Blosnich et al., 2020.

decreased suicidality. Sullins discovered this when he reanalyzed the same data set but included data Blosnich and colleagues had but chose not to use. **Unsurprisingly, people who went to counselling were more suicidal than people who did not go to counselling, and the counseling decreased their suicidality.** Suicidality decreased in minors[205], and in adults decreased dramatically, up to 17 to 25 times lower if he assumed SOCE lasted 1-2 years[206] and still did not increase and may have decreased suicidality if he assumed SOCE lasted 4 or 6 years. [207] Since the data set only included people who currently identified as LGB[208], and people who may have changed and no longer identify as LGB were systematically screened from the data set, the benefit of SOCE may be underestimated. Also, since this U.S. study appears to be the first nationally representative study of people who identify as LGB**, the generalisation can rightly be made that change-allowing therapy does not increase suicidality and may actually reduce suicidality for people who do not change through therapy. This contradicts the claim that not changing through SOCE makes people suicidal. Rather, change-allowing counselling has many benefits, even for people who do not change. Banning SOCE may be banning therapy that is in part is a cure for suicide for LGB-identified people.** Sullins has responded to several comments on his work on SOCE safety.[209]

76. **Sullins also discovered in an additional reanalysis of the same data set, "Those who had undergone [failed] SOCE were no more likely to experience psychological distress or poor mental health,** to engage in substance or alcohol abuse, to intentionally harm themselves, or to think about, plan, intend or attempt suicide, than were those who had not undergone SOCE"[210], **even though SOCE alumni had experienced "higher lifetime and current minority stress, greater childhood adversity, and lower socioeconomic status"[211]. Again unsurprisingly, people who went to counselling had experienced more adversity in multiple ways than people who did not go to counselling. When Sullins accounted for these factors statistically, he found suicidality rates for SOCE alumni were seen to decrease to 5 times lower.[212]**

77. **Meyer and Blosnich have conceded that, in general, people "are not currently suicidal from a SOCE exposure that likely happened 10 or more years earlier**."[213]

78. **Sullins explained the fallacy of association was a pattern in surveys that oppose SOCE. "The four recent studies employing the fallacy of association discussed above, by Salway et al. (2020), Blosnich et al. (2020), Ryan et al. (2020), and**

[205] Sullins, 2022b, p. 3387.
[206] Sullins, 2022b, p. 3378.
[207] Sullins, 2023a.
[208] Sullins 2022b, 2023a.
[209] Sullins, 2023a; 2023b.
[210] Sullins, 2022a, p. 9.
[211] Sullins, 2022a, abstract.
[212] Sullins, 2022a.
[213] Meyer & Blosnich, 2022, p. 2.

Meanley et al. (2020), comprise the most frequently cited population evidence for the conclusion that SOCE therapy increases the risk of suicidal behavior."[214]

79. **An additional biased method in oppositional research is that researchers have indirectly communicated to participants their preferred viewpoint, thereby potentially influencing participant responses and creating a high risk for "good participant" bias.** [215] Researchers have commonly used the pejorative term "conversion" practices" and have asked whether anyone ever "tried to make you", "tried to change you", "tried to stop you", or "tried to convince them", implying the counselling must have been coercive.[216] One study excluded participants who endorsed that they experienced SOCE but not that it was coercive [217] and recurrently directed participants, if stressed during the survey, to contact the Trevor Project known for originating the therapy ban campaign in 2012.

80. **Some researchers offered participants largely[218] or only[219] negative options from which to choose answers on some questions.**

81. **The following all rely on harm-claiming studies that employ the fallacy of association: (1) The American Psychological Association's position statements in opposition to "sexual orientation change efforts"[220] and "gender identity change efforts"[221], (2) a research review by Judith Glassgold, who formerly chaired the APA task force report, in a 2022 edited book[222], (3) the report of the team of scholars at Coventry University headed by Jowett and commissioned by the British National Equalities Office[223], (4) the report for Gov.UK, 2021[224], (5) the report of the team of scholars at Trinity University commissioned by the Irish government[225], and (6) the Standards of Care for the Health of Transgender and Gender Diverse People, published by the World Professional Association for Transgender Health, Version 8[226].**

XIV. MORE REASONS WHY IT CANNOT SIMPLY BE ASSUMED THAT CHANGE-ALLOWING THERAPY CAUSES SUICIDALITY

[214] Sullins, 2022c; see also Rosik, 2020a.
[215] Nichols & Maner, 2008 on "good subject" bias.
[216] Ozanne, 2018; Blosnich et al., 2020; Ryan et al, 2020; Turban et al., 2019; Green et al., 2020.
[217] Green et al., 2020; p.1222.
[218] Dehlin et al., 2014; 2015. For a main question, researchers offered participants a scale that had 3 negative options, 2 positive options, and no neutral options from which to rate their SOCE experience.
[219] Ozanne, 2018.
[220] APA, 2021b.
[221] APA 2021a.
[222] Haldeman, Ed., *The Case Against Conversion Therapy* published by the American Psychological Association with its disclaimer on the copyright page.
[223] Jowett et al., 2021; see critique by Sullins, 2023a.
[224] Gov.UK, 2021.
[225] Keogh et al., 2023.
[226] Coleman et al., 2022.

82. Since suicide risk factors, such as higher prevalence of mental health problems and suicidal thoughts, appear to be much higher for LGBT-identified individuals *irrespective of therapy*[227], one cannot simply presume therapy causes them.

83. There is no research that compares suicidality or completed suicides of people who have had affirmative therapy, change-allowing therapy, or any therapy in general. It is likely that individuals who have sought *any* kind of therapy have had higher suicidality or suicide rates than individuals who have not sought therapy. Nationwide in the U.S., one-third of LGBT identified adolescents and young adults who committed suicide were in some kind of treatment for mental illness, according to findings of a large, national, psychological autopsy study.[228] In a nationally representative study of adolescents who experienced suicidal thoughts, plans, or attempts, 96% had at least one mental health disorder.[229] Worldwide, 90% of people who committed suicide had unresolved mental health disorders. **The researchers' number one recommendation for preventing suicide was treating mental disorders.[230]**

84. One of the main arguments for censoring change-allowing therapy has been a claim that the very viewpoint that some people desire, feel they need, or benefit from change-allowing therapy causes minority stress and the higher rates of mental health disorders and suicidality among LGB-identified individuals, but that an affirmative societal viewpoint and banning change-allowing therapy decreases the higher rates of psychological problems and suicidality in LGB-identified individuals.

85. Yet the originator of the minority stress theory, Ilan Meyer, and co-researchers[231], found in a U.S. representative study of LGB-identified people that, over 50 years—of dramatically and progressively increasing societal affirmation of LGB-identified individuals and earlier onset of coming out and sexual relationships, and they could have added increasing availability of LGB-identity-affirmative psychotherapy and discouraging change-allowing therapy—the psychological stress, reported physical violence, and suicidality of LGB-identified people have progressively worsened. (They used the Generations data set.[232])

86. Studies using *the very same Generations data set* of LGB-identified people over 50 years in the U.S.[233] revealed: (1) the percent of people who reported experiencing sexual orientation change efforts (6% to 8%) has not changed, so change efforts could not have caused the increase in psychological distress and suicidality of LGB-identified people[234], and (2) people who experienced sexual orientation change efforts but did not change sexual attraction incurred no

[227] Sweden: NBHW, 2020; Netherlands: Sandfort et al., 2014, p. 7; systematic review: King et al., 2008.
[228] Ream, 2019.
[229] Nock et al., 2013.
[230] Cavanagh et al., 2003.
[231] Meyer et al., 2021a.
[232] Meyer et al., 2021b.
[233] Meyer et al., 2021b.
[234] Meyer 2021a**;** claims of higher SOCE rates critiqued: Rosik, 2020b.

increase and potentially a dramatic decrease in suicidality[235] and no increase in other mental health harms[236]. (Sullins' SOCE studies used this very same data set.)

87. **The minority stress theory has not ruled out alternative explanations[237] for greater psychological distress in LGBT-identified people. There is evidence that childhood adversity and genetic factors are *causal* for *co-occurrence* of depression and same-sex sexuality.** Findings of a large, prospective, longitudinal, Australian community twin registry study "suggest that genetic factors, childhood sexual abuse, and risky family environment are all involved in the elevated rate of depression in nonheterosexuals", as well as other factors that one twin, but not the other, experienced.[238]

88. **The minority stress theory and the campaign to prohibit change-allowing therapy for same-sex sexuality have fostered for decades avoidance and neglect of research into other explanations of psychological distress and suicidality potentially underlying same-sex sexuality that should be given sober attention. Censoring therapy to explore and treat these does not appear to have decreased psychological distress or suicidality or to have improved mental health.**

XV. GROWING EVIDENCE SHOWS RESEARCHERS WHO REPORT HARM AND RESEARCHERS WHO REPORT BENEFIT ARE STUDYING DIFFERENT SUB-GROUPS

89. **There is growing evidence, coming largely from an ideologically diverse research team of LGB-identity-affirmative researchers and change-allowing therapy researchers working together, that researchers who report change-allowing therapy for same-sex sexuality is helpful and researchers who report harm are studying different sub-populations of individuals who experience same-sex experiences, with the conservative religious who reject an LGBQ label reporting helpfulness and the liberal or nonreligious who accept an LGBQ label reporting harmfulness. Broad generalisations have erroneously been made from research on only one subgroup.[239] The ideologically diverse research team has concluded,**

    a. **"Rejection of an LGBTQ+ label appears to be a marker for a constellation of characteristics, such as conservative religious beliefs,** greater religious participation, prioritization of a religious identity, and the primacy of living in chaste singleness or heterosexual relationship commitments. (Lefevor, Sorrell et al., 2020; Rosik, Lefevor, & Beckstead, 2021[b])."[240]

    b. "Thus, the underrepresentation of non-LGBTQ+-identified sexual minorities in research on SOCE generally and change-oriented psychotherapies in particular

[235] Sullins, 2023c, 2023a, 2023b, 2022a.
[236] Sullins, 2022a.
[237] Bailey, 2020.
[238] Zietsch et al., 2012.
[239] Lefevor, Beckstead, et al., 2019a; Lefevor, Sorrell, et al, 2019b; Lefevor et al., 2021; Rosik, Lefevor, & Beckstead, 2021a; 2021b; Sullins & Rosik, 2024; erroneous generalizations have been made: Rosik, 2022.
[240] Rosik, Lefevor, & Beckstead, 2021a, pp. 195-196.

may plausibly *misrepresent* the experiences of those individuals who are traditionally religious. **We hope establishing there is in fact a subgroup of people who report most goals of SOCE to be helpful will spur more research into identifying who these people are, rather than simply foreclosing clinical options for them."**[241]

90. Research does not consistently support a view that traditional religions cause mental health disparities or suicidality for people of traditional religions who experience same-sex sexuality or a view that those of traditional religion would have better mental health if they converted to liberal or no religion.

a. A meta-analysis from 73 studies found a positive relationship between spirituality or religious belief with health, but this relationship disappears or becomes negative when research participants are solicited from LGB specific venues such as LGB bars or clubs, as occurs in 75% of studies regarding religion or spirituality and the health of individuals who have same-sex sexuality or incongruent gender identity experiences.[242]

b. The originator of the minority stress theory and a co-author found attendance at an LGB-identity non-affirming church was associated with higher "internalized homophobia" but was unrelated to global self-esteem.[243] Also, **"There was no main effect of non-affirming religion on mental health," contrary to the researchers' expectations.**[244]

c. Negative views of homosexuality among traditionally-religious same-sex attracted people likely represent movement toward religious beliefs, not beliefs about self, self-hatred, or shame. This is because they perceive same-sex attraction feelings to be feelings they *have*, *not* who they *are*.[245]

d. Those who follow their traditional faiths that reject same-sex relationships are no less happy, mentally healthy, satisfied with life, resilient, and flourishing than those of faiths that accept same-sex relationships or those of no faith according to U.S. nationally representative research[246], a growing number of studies by an ideologically diverse research team[247], and the Faith and Sexuality Survey in the U.K.[248]

e. A study found that same-sex attracted people in Nigeria who were traditionally religious and believed same-sex behaviour was a sin reported greater religious attendance and perceived social support and less suicidality

[241] Rosik, Lefevor, & Beckstead, 2021a, p. 198, emphasis added.
[242] Lefevor et al., 2021, abstract; see also Rosik, 2021a.
[243] Barnes & Meyer, 2012, p. 509.
[244] Barnes & Meyer, 2012, abstract.
[245] Rosik et al., 2021a; Hallman et al., 2018.
[246] Barringer, 2020; Barringer & Gay, 2017, abstract.
[247] Lefevor, Davis, et al., 2021; Lefevor, Sorrell, et al., 2019; Rosik, Lefevor, & Beckstead, 2021c.
[248] Ozanne, 2018, p. 19.

than those who were of liberal religion[249]. Another study found that religious Black American same-sex attracted people of conservative beliefs (assessed as "homonegativity") were more resilient [250] than those of progressive religious beliefs. Yet researchers in these studies remarkably and in direct contradiction to their findings, concluded that the traditionally religious would benefit from becoming religiously progressive.

f. **A survey of 23,001 LGBTQ+ identified youths recruited from all 50 U.S. states through LGBTQ+ identity advocacy organisations conducted by LGBTQ+-identity-affirmative researchers found religious schools that used no LGBTQ+-identity-affirmative methods ranked among the safest schools for LGBTQ+ identified students in rates of negative student comments, victimization, and bullying, even compared to private non-religious schools that used all the recommended LGBTQ+ identity affirmative methods.**[251]

g. **The large Healthy Minds survey conducted in 140 U.S. universities (135,344 participants) from 2020 to 2021 found, overall, no differences in anxiety or suicidal ideation for LGBT-identified students across Catholic, Evangelical, "Other Christian" (Episcopalian, Lutheran, Presbyterian, Baptist), and nonreligious universities. In fact, importance of religion was generally associated with lower suicidal ideation and anxiety across universities.[252]**

91. **Therapists should be promoting belongingness, not identity affirmation ideology.**

a. **A survey of LGB-identified and non-LGB-identified same-sex-attracted adults found that "meeting needs for connection, intimacy, and mutual understanding was the strongest predictor of satisfaction across all options."** The researchers compared satisfaction in 4 relationship groups—single and sexually abstinent, single and not abstinent, in an opposite-sex relationship, and in a same-sex relationship. These groups likely reflect different beliefs about same-sex behaviour.[253]

b. **Non-LGB-identified people may not experience belongingness in an LGBT-identity community, because they do not share an LGBT-identity lifestyle and culture and do not find it fulfilling.[254]** Belongingness and community are not unique to liberal- or non-religious LGB-identity communities that are not a fit for everyone. Supportive communities that hold MoU unapproved viewpoints can enhance mental health and reduce suicidality.

92. **The MoU viewpoint has led well-meaning therapists to initiate unethical, unhelpful, coercive, LGB-identity-*affirmative* conversion therapy on** non-LGB-

[249] Ogunbajo et al., 2022.
[250] Walker & Longmire-Avital, 2013.
[251] Kosciw et al., 2017, Appendix 2; reviewed in Haynes, 2019.
[252] Dyer & Erickson, 2023, p. 184.
[253] Lefevor, Beckstead, et al., 2019.
[254] Byrd, Nicolosi, & Potts, 2008.

identified clients who do not want or consent to it and do not feel it is affirmative of them.[255] In structured interviews, participants desiring change-allowing therapy preferred therapists who shared their values and beliefs.[256]

93. **The MoU violates its own ethical standard and is self-prohibiting**. For same-sex sexuality, the MoU favours an LGBT-identity as inherently preferable to traditional-religious-identity/non-LGBT-identity and supresses support for behavioural expression of the latter which is abstinence or heterosexual behaviour. "For people who are unhappy about their sexual orientation or their gender identity," it supports therapy to help them "reach a greater degree of self-acceptance." This appears to mean helping them change to a viewpoint that their same-sex or discordant gender identity feelings or behaviours are *who they are*, hence attempting to change their "orientation", to speak in MoU terms, from religious-identity/non-LGBT-identity to LGBT-identity. For discordant gender identity, the MoU prioritises body "conversion therapy" over exploratory subjective feelings "conversion therapy". The MoU signatories meet their own definition of conversion therapy: "a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis." The MoU also demonstrates diversity ignorance and a biased agenda. It says, "Ethical practice in these cases requires the practitioner to have adequate knowledge and understanding of gender and sexual diversity and to be free from any agenda that favours one gender identity or sexual orientation as preferable over other gender and sexual diversities."[257] The MoU condemns itself as unethical.

XVI. PROFESSIONAL ORGANISATION SUPPORT FOR CHANGE-ALLOWING THERAPY; THERE IS NOT A PROFESSIONAL CONCENSUS IN OPPOSITION

94. **A number of medical, mental health, and social science organisations have accepted the right of distressed clients to change-allowing therapy for undesired same-sex feelings or behaviours or gender discordance. They include:** the International Foundation for Therapeutic and Counselling Choice (serving about 35 nations), Federation of International Catholic Medical Associations (FIAMC, about 80 member organisations), American Association of Physicians and Surgeons, American College of Pediatricians, Christian Medical and Dental Associations (USA), Catholic Medical Association (USA), Society of Catholic Social Scientists (USA), Alliance for Therapeutic Choice and Scientific Integrity (USA), American Association of Christian Counsellors, Christian Medical Fellowship (UK).[258]

95. **An increasing number of medical and mental health professional organisations in the United Kingdom and internationally are issuing warnings about "gender**

[255] Przeworski et al., 2021; Weir, 2017.
[256] Nicolosi, Byrd, & Potts, 2000; Throckmorton & Welton, 2005, p. 16; SCIO, March 2024.
[257] MoU, July 2024.
[258] The Full Expert Report includes links for these at "XVI. Professional Organisation Support…."

affirmative" medical interventions and, among these, many are moving toward prioritising psychotherapy, in contradiction to the MoU that accepts gender-affirmative interventions and opposes prioritising psychotherapy to resolve gender dysphoria, at least if there is a disapproved viewpoint. **The Academy of Royal Medical Colleges[259] (that has 23 U.K. and Irish royal colleges and faculties as members)** is among these organisations (in support of the Cass review), and more are listed with links in the Full Expert Report.[260]

96. There is not a professional consensus in support of the MoU's affirmative-only position on discordant gender identity, sexuality, and therapy. Organisation statements that oppose "sexual orientation and gender-identity change efforts" are opinions of guilds, not scientific statements. The MoU is an example.

CLOSING

XVII. COMMENTS ON THE MEMORANDUM OF UNDERSTANDING

97. The MoU indicates it supports "appropriate" research. I suggest, however, that the aforementioned research may never have been properly considered by the authors or signatories.

98. The MoU is viewpoint discrimination. It violates a client's most profound and fundamental freedoms and rights to self-determination in many domains, hence is unethical and unjust. In light of existing research, it is not possible to make a case of incontrovertible scientific justification to take away these freedoms and rights. The MoU remarkably polices thoughts, speech, values, beliefs, ethics, conscience, sexual feelings, sexual behaviours, gender identity, gender expression, procreative relationships, marriage, family, many religions, and many cultures.

99. The MoU lacks clarity as to whether therapists may *ever* offer therapy that helps a person decrease distress about same-sex sexuality or gender identity and that may or may not result in reduction or change in same-sex behaviour, attraction to engage in it, or discordant gender identity or expression. Without clarity, therapists will be afraid to provide such support. If the MoU does allow such support in some cases, it should allow anyone such support for whatever reason they wish without viewpoint discrimination. Professional support may be needed or desired for many reasons: to reduce risk of HIV transmission, fulfil a seminary student's or priest's calling to be celibate, treat behaviours that meet diagnostic criteria for a standard psychiatric diagnosis, result from trauma, are putting at risk a marriage and family, conflict with a person's preferred religious identity, or were unfulfilling, and to treat detransitioners and gender dysphoric people who prefer or medically require non-medical interventions.

100. The reality that the signatories of the MoU continue to promote the gender-affirmative-only approach in the face of the comprehensive four-year Cass

[259] https://www.aomrc.org.uk

[260] The Full Expert Report includes links for these at "XVI. Professional Organisation Support…".

Review is evidence as to how far unscientific affirmative gender ideology has captured the professional organisations. It demonstrates that professional eminence is not scientific evidence.

101. The United Kingdom has several years of experience with a "conversion therapy" ban because of the MoU, and the result has been a marked reduction of access to care for gender dysphoric young people as well as for unacknowledged non-LGBT-identified people. This has been a disaster. As the Cass Report calls for NHS-England and potentially the U.K. to change fundamentally away from an affirmative approach to psychosocial treatment for gender dysphoria, the MoU is simultaneously still being permitted, without scientific justification, to coerce an affirmative-only approach on therapists. The need for resolution is urgent.

102. The social stigma and marginalizing, if not social erasing, of non-LGBT-identified people has left them in a precarious and protracted situation of not getting care. Many of them are trying to save their marriage and family and some are suicidal. Under the MoU, while LGBT-identified people receive therapy, non-LGBT-identified people are reporting they cannot get help from accredited therapists. This critical situation is dangerous and unjust. Professionals are left generally untrained in understanding and caring for this population.

103. Studies published largely since the Coventry Review reveal a subpopulation of sexuality diverse people for whom LGB-affirmative care is not multiculturally sensitive, appropriate, or proven safe or effective. Recent research has found client-centred therapy they may desire improves mental health, reduces sexuality distress and suicidality, and is effective in many cases in reduction or some degree of change in their same-sex behaviour or attractions. Research that has claimed harm from such therapy has now been shown to have made significant methodological errors, to have largely or entirely excluded this non-LGB-identified client subpopulation, and to have drawn invalid generalisations. Prohibiting care that is affirming, safe, and effective for non-LGB-identified people and consistent with their preferences, values, beliefs, and life goals is not scientifically justified, and coercing LGB-affirming treatment on them is multiculturally inappropriate, unethical, and harmful to the point that it can be dangerous.

104. A viewpoint that distressed same-sex attracted or gender-discordant individuals could not possibly freely seek professional help to decrease their distress and explore their potential to more closely align their sexuality and gender perception with their personal fulfilment, mental health needs, religious self, and/or desired or actual opposite-sex marriage with family apart from "externalised and internalised oppression" is itself prejudiced and oppressive.[261] Exercising these preferences is a human right. The assumption of coerced external motivation denies that these individuals can have agency that is motivated by self-knowledge, love of their spouse and children, and love of the beauty of their religion that brings them happiness. There is nothing inherently

[261] UKCP, no date, p. 4.

wrong with a preference for exploring one's capacity for a procreative relationship. Having this preference should not be prohibited or stigmatised on an assumption that it could only be the result of stigma or is stigmatising.

105. **The reality that some clients do not find an LGBT identity fulfilling and desire change allowing therapy may be an offensive or painful reality to some others. An ethical approach** is not to stigmatise or forbid them. Surely a compassionate approach can allow those who want therapy to explore their sexuality or gender identity comprehensively to have the freedom to do so. This is the ethical stand to take, and taking away this freedom is unjust.

106. **Viewpoint gate keeping restricts *clinical* curiosity and inquiry** by mental health and medical practitioners and, not the least, the clients themselves. This is an injustice to care givers, patients, and to society, and it is harmful. I personally benefitted from being a member of a professional peer tutorial group for 14 years in which professional members confidentially discussed anonymatised cases that included LGBT-identity-affirming care and change-allowing care. This professionally enriching experience was possible because members did not require each other to agree, and members were interested in varying viewpoints.

107. **Subjecting *research* evidence to the reduced scrutiny of one viewpoint in the MoU, that cannot under any circumstances be challenged, has resulted in loss of rational debate**, scientific evidence, criticality, freedom of thought, academic freedom, and freedom to research and think. Such unfortunate loss of diversity of viewpoint is a major obstacle to progress in research and treatments. It is important that there be openness to new evidence in ongoing scientific and academic debate. For this to exist, freedoms for individuals to hold beliefs and viewpoints are required.

108. **The inherent right for desiring people to have help to live out their sexuality and gender as they see fit is prohibited in the MoU. The MoU signatories, in effect, gate-keep non-LGBT-identified people from exiting MoU-mandated sexuality and gender identity.**

109. **In light of these concerns, professional ethics require that professionals and clients have these rights:**

    a. **Mental health professionals should have a right to religious viewpoint freedom on sexuality, gender identity, and therapy that is culturally sensitive and appropriate for traditionally religious clients and a right to offer professional practice consistent with this viewpoint to desiring patients, and professional organisations should not take away these rights.**

    b. **Clients should have the right to choose an *accredited* professional to care for them who shares their worldview and is able to help them from within it and should no longer be deprived of this.** MoU signatory organisations are denying this right on the basis of viewpoint discrimination that acts against religious

and cultural values and goals for marriage and family. Many clients desire a professional therapist who is able to treat them from within their religious worldview and have said they have felt having such a therapist was extremely beneficial for them.

c. Viewpoint freedom requires that professionals, who share the traditional religious worldview of some clients on sexuality and gender and who are open to their therapy goals, be allowed professional training and membership in professional organisations.

d. **Professional ethics should require that professionals receive training in similarities and differences among conservative religious, liberal religious, or non-religious people who experience same-sex or gender-discordant feelings or behaviours. LGBT-affirmative approaches are not experienced as a fit for all and may marginalise, stigmatise, pathologise, and harm** people who have same-sex attraction feelings or incongruent gender identity feelings and who do not experience these feelings they have as defining who they are.

110. The difficulty with therapy bans was succinctly expressed in the court complaint of Dr. David Schwartz, a psychotherapist who successfully supported the right of his clients to change-allowing therapy for same-sex attraction in New York City. As a result of Dr. Schwartz's case, the city council voted to repeal its own therapy ban.[262] His complaint said therapy censorship allows therapists "to assist individuals in directing and redirecting their sexual desires and relationships in any imaginable direction except towards congruence with the natural reproductive function—that is, towards stable heterosexual attraction" aligned with objective sex and its biological reproductive nature.[263] "Indeed, the ability to reproduce—to be a father or mother to children, as the case may be, and to participate in the small society that consists of two parents and their children—has been widely held across culture and across history to be one of the greatest sources of joy in life."[264] Professional organisations should not prohibit clients, who desire this kind of life or "who have already entered into a heterosexual marriage, given life-long promises, and begotten or borne children"[265] from having support to live this way more successfully, easily, and enjoyably.

XVIII. CONCLUSION

111. The MoU prohibits much warranted therapy for those who desire it and wrongly prohibits therapists and counsellors who are willing to offer such professional care. These prohibitions violate fundamental client rights without the necessary incontrovertible scientific evidence to justify doing so. Lack of clarity in the MoU may have seriously harmful unintended consequences. The MoU prohibitions are harmful and unethical.

[262]Schwartz v. City of New York, 2019. Hobson, 2019.
[263] Schwarz v. City of New York, 2019, p. 23.
[264] Schwarz v. City of New York, p. 17.
[265] Schwarz v. City of New York, p. 18.

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ist University.

XX. EXPERT DECLARATION

I declare the following:

1. That I understand that my duty in providing written reports and giving evidence Is to help the court; and that this duty overrides any obligations to the party by whom I am engaged or, the person who has paid or I liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees Is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am Instructed If, between the date of my report and the hearing, there Is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion
9. I have not, without forming an independent view, Included or excluded anything which has been suggested to me by others, Including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
11. I understand that –
    a. My report will form evidence to be given under oath or affirmation;
    b. Questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

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

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

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

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

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

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

…….
Laura Haynes, Ph.D.

9 January 2025
……..
Date

XXI. CURRICULUM VITAE:

Laura Haynes, Ph.D., Psychologist
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9 January 2025

Laura Haynes, Ph.D. is a psychologist retired from clinical practice after 40 years of experience. She now reviews research, writes, and speaks on sexuality and gender internationally. Her mission is advocating for the freedoms and rights of individuals who feel distress from their sexuality or gender identity to receive professional and pastoral counseling to decrease distress, improve psychological well-being, and manage, reduce, or change undesired same-sex attraction or behavior or undesired gender-sex discordant identity or expression, and to live according to the preferences, beliefs, and values that bring them true happiness. Dr. Haynes has served as an expert

internationally for professional organizations, members of parliaments and legislatures, courts, United Nations delegates, and high-level government officials. People in over 80 nations and in 20 languages have heard, read, or received research reviews from Dr. Haynes.

EDUCATION:

BIOLA UNIVERSITY, Rosemead Graduate School of Psychology
La Mirada, California (free standing school in Rosemead when I graduated).
Ph.D., Counseling Psychology (Clinical emphasis), May 1977
M.A., Counseling Psychology (Clinical emphasis), June 1974

SOUTHERN METHODIST UNIVERSITY
Dallas, Texas
M.A., Experimental-General Psychology, May 1972

WESTMONT COLLEGE
Santa Barbara, California
B.A., Sociology (with equivalent of a minor in New Testament Greek), June 1970

FULLER THEOLOGICAL SEMINARY
Pasadena, California
M.A., Theology, June 1979

CERTIFICATIONS:

1978 to present:	California Licensed Psychologist (PSY5850).
2016	EMDR Trained.

POST LICENSE TRAINING (past 10 years):

2023	Reintegrative Therapy, audited basic course. Luke Dougherty, LMFT, Certified Reintegrative Therapist, instructor.
2016-2018	EMDR peer-consultation group led by Curt Rouanzoin, Ph.D., Approved EMDR Consultant, Instructor. Served as a Senior Facilitator and Specialty Presenter for the EMDR Institute until 2017.
2003-2017	Psychoanalysis reading group and case tutorial group with Lawrence E. Hedges, Ph.D., Psy.D, ABPP, ABFE, California Board of Psychology

Expert Witness, founding training and supervising psychoanalyst, Newport Psychoanalytic Institute (NPI).

PROFESSIONAL ORGANIZATIONS:

2020-present Sexual and Gender Identity Task Force Member, Christian Medical and Dental Associations (CMDA).

2018-present International Foundation (previously Federation) for Therapeutic and Counselling Choice: Executive Board Member (as of 2023, previously General Board Member), Country Representative for the U.S.A., Chair (since 2023, previously Member) of Science and Research Council. IFTCC Award, October 19, 2024, to Chairman, IFTCC Science and Research Council: "In Recognition of her Scholarship Excellence in Service to the IFTCC, Internationally". Poland.

1993-present Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) (formerly National Association for Research and Therapy of Homosexuality): Member 1993 to present, Member Research Committee 2017 to present.

1992-1995 Christian Association for Psychological Studies—Western Region (CAPS-West, covering the western United States and western Canada): President Elect, 1992-1993, President 1993-1994, Past President 1994-1995.

1979-present American Psychological Association, Member since 1979 (APA), Lifetime Member.

RELEVANT WORK EXPERIENCE:

2019 ALLIANCE DEFENDING FREEDOM
Research consultant for expert declarations and cross examination questions.

2018-present Speaking and writing about research on sexuality and gender as they relate to the right to change-exploring therapy in law.

1978-2018 Private practice, variously in Hacienda Heights and Tustin, California, U.S.A.
Areas of Practice: Depression, Anxiety, Homosexuality, Marriage, Psychological Evaluations, Faith-Based Concerns.

PRESENTATIONS: (Past 10 years)

Confidential	Addressed or gave interviews to United Nations diplomats, high-level government officials, and members of parliaments.
2016-present	Various oral and written testimonies presented to legislative hearing committees of U.S. states on proposed legislation.
2024-10-20	Introducing the Science and Research Council. Presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.
2024-10-19	Gender Dysphoria Treatment: The Cass Review and Other Research Updates. Presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.
2024-4-27	Protecting the Legal Right to Therapy: Support from Research on Sexuality and Gender Published in English. Webinar for the International Christian Medical and Dental Association—Latin America.
2024-4-24	Protecting the Legal Right to Professional and Pastoral Counselling Support from Research on Sexuality and Gender. IFTCC Parliamentary briefing, London.
2024-3-19, 20	LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This—Latest Update. Tepeyac Leadership Institute. Online presentation for Western students; repeated for international students.
2023-11-4	Protecting the Right of Children in Barbados to Sing That Jesus Changes Lives. Family-Faith-Freedom, Barbados. Online conference.
2023-10-20	Research and Leading Clinicians on Gender Dysphoria Psychotherapy. Invited plenary presentation. Conference of the International Foundation for Therapeutic and Counselling Choice. Poland.
2023-3-21, 22	LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This--Updated. Tepeyac Leadership Institute. Online presentation for Western students; repeated for international students.
2022-12-7	Transing Kids Is a Bad Idea—3 Reasons Why. Parliament of the European Union, Brussels, Belgium. Educational meeting for parliamentarians and staffers sponsored by Christine Anderson, Member of the European Parliament representing Germany (political party AfD—Alternative for Germany).
2022-10-29	Transing Kids Is a Bad Idea—3 Reasons Why. Marriage, Sex, and Culture (MSC) Conference, Transing Kids: A Good Idea? Part 10. (MSC is based in the United Kingdom.) Zoom event with Christine Anderson, Member of

	the European Parliament representing Germany (political party AfD—Alternative for Germany).
2022-10-17	Pathways to Heterosexuality and Homosexuality; Psychoanalytic Theories Made Easy. Plenary presentation. Conference of the International Federation for Therapeutic and Counselling Choice. Hungary.
2022-9-27, 28	LGBT Ideology and Activism Are Causing Serious Harms: Let's Change This. Belize City, Belize. Presented at the invitation of the Diocese of the Catholic Church that serves Belize City and the national capitol city, Belmopan. Separate presentations to priests, lay leaders in Diocese churches, superintendents responsible for the education of 70% of secondary school students in the nation of Belize, and an ecumenical group of Protestant pastors.
2022-8-6	Research on Gender Incongruence: Causes, Change, and Treatment. Online presentation, Conference: Critical Conversations on Gender and Identity. Hendricks Center, Dallas Theological Seminary. Dallas, Texas.
2022-8-6	Research Help for Sexuality Questions the Church Faces Today: Causes, Change Through Life Experience, Therapy, and Faith-Based Care. Online presentation, Conference: Critical Conversations on Gender and Identity. Hendricks Center, Dallas Theological Seminary. Dallas, Texas. Zoom.
2022-4-18	Health and Human Services Section 1557 Proposed Amendment—Opposed. Testimony on behalf of the IFTCC to the Office of Information and Regulatory Affairs (OIRA) of the White House Office of Management and Business (OMB).
2022-3-22	LGBT Ideology and Activism Are Causing Serious Harms; Let's Change This. Tepeyac Leadership Institute. Online presentation for Western students.
2021	Expert interview in documentary: D. James Kennedy Ministries, The Tragedy of Gender Confusion.
2021-Nov. 6	Protecting the Right to Therapy: Same Sex Attraction and Incongruent Gender Identity: Research on Causes and Change Through Life Experience, Therapy, and Faith-Based Care. Webinar presentation, co-sponsored by Dallas Theological Seminary and the Christian Medical and Dental Associations.
2021-Oct. 18	Research on Gender Incongruent Identity: Causes, Change, Treatment, & Bans. Plenary presentation, conference of the International Federation for Therapeutic and Counselling Choice, Hungary. Simultaneous translations.

2021-Oct. 17&18 Pathways to Heterosexuality and Homosexuality: Psychoanalytic Theories Made Easy. Workshop presented on both dates, conference of the International Federation for Therapeutic and Counselling Choice, Hungary. Simultaneous translation.

2021-Sept. 22 Haynes, L. & Davidson, M. IFTCC Oral Submission to members of the Judicial Committee of the New Zealand Parliament on the "Conversion Practices Prohibition Legislation Bill". https://www.facebook.com/JUSCNZ/videos/2962519317294188/?extid=NS-UNK-UNK-UNK-IOS_GK0T-GK1C

2021-Sept. 2 Conversion Therapy: Should It Be Banned? Protecting the Right to Therapy. Invited webinar for the International Christian Medical and Dental Association. Simultaneously translated into Mandarin, Arabic, and Russian. https://www.youtube.com/watch?v=1ZSd1fmcvZk

2021-July 17 Introducing the International Federation for Therapeutic and Counselling Choice (IFTCC) and The Highlights of the IFTCC Report on Gender to the Bulgarian Constitutional Court. The Summit (conference), Ruth Institute, Lake Charles, Louisiana.

2021-June 3 SOGIE [Sexual Orientation and Gender Identity and Expression] Challenges and Change Allowing Therapy. Interview for Media Matters, radio podcast for the Christian Medical and Dental Associations (USA). https://cmda.org/cmda-matters/

2020-Nov. 28 Protecting the Right to Therapy. Updated and invited presentation, virtual conference of the International Federation for Therapeutic and Counselling Choice.

2020-Nov. 28 Same Sex Attraction and Childhood Gender Dysphoria May Have Treatable Psychological Causes. Updated and invited presentation, virtual conference of the International Federation for Therapeutic and Counselling Choice.

2020-Nov. 28 'Tools in the Toolbox": Refining and promoting best practices in supporting SAFE-T (sexual attraction fluidity exploration in therapy)? Plenary panel presentation and discussion. Michael Gasparro (U.S.), Dr. Laura Haynes (U.S.), Dr. Julie Hamilton (U.S.),
Dr. Melvin Wong (U.S.), Dr. Mike Davidson (U.K.), Dr. Ann Gillies (Canada), Dr. (med) Keith Vennum (U.S.).

2020-Nov. 27 Politics and Society: Therapy bans, "equality" legislation, civil unions, and imposed sex education: How do we strive for freedom, maintain rights and
promote self-determination in our work and witness: Plenary panel presentation and discussion. Dr. Melvin Wong (U.S.), Roger Kiska (U.K.),

Dr. Laura Haynes, (U.S.), Walt Heyer (U.S.), Dr. Ann Gillies (Canada), Alexis Lundh (Norway).

2020-Nov. 27 Science and Research: Skewed sampling, ideological monocultures and viewpoint discrimination: How is ideology masquerading as science—how do we tackle the misuse of scientific data? Plenary panel presentation and discussion. Dr. (med) Andre Van Mol (U.S.), Agnieszka Marianowicz-Szczygief (Poland), Dr. Laura Haynes (U.S.), Dr. Julie Hamilton (U.S.), Dr. (med) Peter (U.K.), Dermot O'Callaghan (U.K.), Dr. Christopher Rosik (U.S.A.).

2020-Sept. 26 Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes—and Other Confessions of the American psychological Association—Updated. Invited plenary presentation, conference of the Catholic Medical Association, Philadelphia, Pennsylvania.

2020-April 3 Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes, Change allowing Therapy is Non-Aversive—and Other Confessions of the American psychological Association—Updated. Webinar, Catholic Psychotherapist Association.

2019-Nov. 16,17 Workshop on Protecting the Right to Therapy, a repeated workshop, also panel Q&A of speakers. Conference, International Federation for Therapeutic and Counselling Choice, Hungary. Trained therapists, formerly LGBT identified individuals, and others from 25 nations in protecting the right to change-allowing therapy in their countries.

2019-Nov. 16 Protecting the Right to Therapy. Conference plenary presentation, International Federation for Therapeutic and Counselling Choice, Hungary.

2019-Sept. 27 Trending Issues: Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes—and Other Confessions of the American Psychological Association, Updated, Alliance for Therapeutic Choice and Scientific Integrity. Convention, Phoenix, AZ

2018-Nov. 19 Sexual Attraction is Not Biologically Determined, Changes, and May Have [Treatable] Psychological Causes; Change Therapy Uses Non-Aversive Methods—and Other Confessions of the American Psychological Association. Convention, Catholic Social Workers National Association, Washington D. C.

2018-Oct. 15 Protecting the Right to Therapy in the United Kingdom." Invited presentation, International Federation for Therapeutic and Counseling Choice, London, UK, https://youtu.be/SHzCAFi6NWU

2018-Sept. 21	"Sexual Orientation and Childhood Gender Dysphoria Change, May Have (Treatable) Psychological Causes, and Other Confessions of the American Psychological Association." Convention, Catholic Medical Association convention, Dallas TX, https://nsp.performedia.com/cma/aec18/welcome#/ then scroll to choose 9/21/2018, scroll to choose Laura Haynes, Ph.D. talk).
2017-Sept. 20	Panel Presentation on the National Task Force for Therapy Equality, May 2, 2017, "Report to the Federal Trade Commission; In Their Own Words: Lies, Deception, and Fraud—Southern Poverty Law Center, Human Rights Campaign, and National Center for Lesbian rights' Hate Campaign to Ban Psychotherapy for Individuals with Sexual and Gender Identity Conflicts." Conference, Alliance for Therapeutic Choice and Scientific Integrity, Salt Lake City, Utah.
2015-2016	Several oral testimonies presented to the Board of the California Association of Marriage and Family Therapists on various proposed organization position statements on treating undesired same sex attraction.

PUBLICATIONS AND SUBMISSIONS (past 10 years):

2020	Reviewer, *Journal of Marriage and Family*
2019ff	Reviewer, *Journal of Human Sexuality.*
2011-2018	Reviewer, *Linacre Quarterly.*
1997ff	Guest Reviewer, *Journal of Psychology and Theology.*
2012-present	Various written testimonies submitted to legislative hearing committees in several US states on proposed legislation and to city councils on proposed ordinances.
2025-1-9	Full Expert Report on The Coalition Against Conversion Therapy Memorandum of Understanding on Conversation Therapy in the UK. (book)
2025-1-9	Summary Expert Report on The Coalition Against Conversion Therapy Memorandum of Understanding on Conversation Therapy in the UK.
2024-10	(English) Marianowicz-Szczygiel A., Margasinski A., Haynes L., Smyczynska J., van Mol A. Pietruszewski K., Próchniewicz J., Chazan B., Wozinska K., Chochel K., Białecka B., Kolodziejczyk A. (2024). Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues.

Association of Christian Psychologists in Poland, Warsaw. https://www.spch.pl/wp-content/uploads/2024/10/2024-SPCh-Standards_03.pdf

(Polish) Marianowicz-Szczygieł A., Margasiński A., Haynes L., Smyczynska J., van Mol A., Pietruszewski K., Próchniewicz J., Wozinska K., B. Chazan, Chochel K., Białecka B., Kołodziejczyk A. (2024). Standardy i wytyczne Stowarzyszenia Psychologów Chrześcijańskich w zakresie diagnozy oraz terapii dzieci i młodzieży z problemami identyfikacji płciowej. Warszawa: Stowarzyszenie Psychologów Chrześcijańskich. https://www.spch.pl/zespol-spch-ds-plci-i-seksualnosci/

2024-4-2 IFTCC Submission to Ending Conversion Practices in Scotland: Consultation—Opposed. https://iftcc.org/iftcc-submissions-to-scotlands-conversion-practices-consultation/

2024-3-15 Haynes, L., Sullins, P., & Rosik, C. The IFTCC Is Specially Positioned to Help the Government Fulfill Its Plan to Improve the Lives of All People of Sexual or Gender Diversity in the United Kingdom Without Exception.

2024-2-6 Response to Emily Sargent's "Invited" Investigation in the Times on Former LGB-Identified Persons Who Benefit from Change Allowing Therapy. https://core-issues.org/response-to-emily-sargents-invited-investigation-in-the-times-on-former-lgb-identified-persons-who-benefit-from-change-allowing-therapy/

2024-1-31 Submission of the IFTCC to the World Health Organisation: A Guideline for Adult Hormone Treatment Would Be Scientifically Unfounded and Premature. https://iftcc.org/submission-of-the-iftcc-to-the-world-health-organisation/

2023-6-19 IFTCC Testimony Opposing California AB 665 Minors Consent to Treatment – Politicians Will Take Children Away From Parents—Letter to California Senators.

2023-Feb. 13 IFTCC Testimony Opposing Oregon HB2458 Therapy Ban Bill for Adults. https://archive.iftcc.org/testimony-opposing-oregon-hb2458-therapy-ban-bill/

2023-Jan 16 Testimony of the International Federation for Therapeutic and Counselling Choice in Opposition to Therapy Ban Bill HF16 in the State of Minnesota, U.S.A. https://archive.iftcc.org/testimony-opposing-minnesota-hf16-therapy-ban-bill/

2022 Davidson, M., Haynes, L., James, S., & May, P. An International Declaration on "Conversion Therapy" and Therapeutic Choice. https://iftcc.org/the-declaration/

2022	Davidson, M., Haynes, L., James, S. Extract from the submission to the U.K. Government's Consultation on Conversion Therapy. https://archive.iftcc.org/extract-from-the-submission-to-the-uk-governments-consultation-on-conversion-therapy/
2022-Sept 9	Open Letter to the U.S. Department of Education from the IFTCC—The DOE's Intention to Coerce Gender Ideology Compliance in Schools by Changing Title IX Will Have Seriously Harmful Consequences. https://archive.iftcc.org/open-letter-to-the-us-department-of-education-from-the-iftcc-the-does-intention-to-coerce-gender-ideology-compliance-in-schools-by-changing-title-ix-will-have-seriously-harmful-consequences/
2022-May 3	San Diego County, California, U.S.A. Proposed Ordinance Based on the U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) While Defining Woman by Gender Identity—Opposed. IFTCC Testimony Submitted to the San Diego Board of Supervisors. https://archive.iftcc.org/haynes-l-may-3-2022-san-diego-county-california-u-s-a-proposed-ordinance-based-on-the-u-n-convention-on-the-elimination-of-all-forms-of-discrimination-against-women-cedaw-while-defining-wo/
2021-Sept. 24	Matters Arising from Questions put to the IFTCC Oral Presentation on Thursday 23rd September 2021. IFTCC letter to the Justice Select Committee of the New Zealand Parliament. https://archive.iftcc.org/letter-to-new-zealand-justice-select-committee-24th-september-2021/
2021 Sept. 8	IFTCC Submission to New Zealand Government's Proposed "Conversion Practices Prohibition Legislation Bill" September 2021. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2021/09/IFTCC-Submission-to-NZ-MPs-Opposing-Conversion-Practices-Prohibition-Bill-2021-9-7-4-pp-with-endnotes-.pdf?x86993
2021-June 19	International Federation for Therapeutic and Counselling Choice expert opinion on the constitutional meaning of "sex" and "gender": Medical gender affirming treatment, Case no. 6 of 2021, Bulgarian Constitutional Court. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2021/07/IFTCC-Brief-for-Cassian-Constitutional-Courts-in-Bulgaria-on-Gender-2021-6-19-FINAL-Full-edits-English-Post-2021-7-2-.pdf?x28941
2021-April 20	Davidson, M. & Haynes, L. for the IFTCC Science and Research Council. Letter to Doug Beattie, MLA North Ireland Assembly, on "Conversion Therapy".

2021 Williams, W.V., Brind, J., Haynes, L., Manhart, M.D., Klaus, H., Lanfranchi, A., Migeon, G., Gaskins, M., Seman, E.I., Ruppersberger, L., Raviele, K.M. (2021). Hormonally active contraceptives, part II: Risks acknowledged and unacknowledged, *The Linacre Quarterly,* in press. https://doi.org/10.1177/0024363920982709

2021 Williams, W.V., Brind, J., Haynes, L., Manhart, M.D., Klaus, H., Lanfranchi, A., Migeon, G., Gaskins, M., Seman, E.I., Ruppersberger, L., Raviele, K.M. (2021). Hormonally active contraceptives, part I: Risks acknowledged and unacknowledged, *The Linacre Quarterly,* online, 1-23. https://doi.org/10.1177/0024363920982709

2020-Spring Uncovering treatable causes of same-sex attraction and childhood gender dysphoria. *The Pulse* (an online publication of the Catholic Medical Association).

2019-Dec. 21 Davidson, M.R., Rosik, C., Moseley, C., and Haynes, L. Submission to Victor Madrigal-Borloz Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity. For consideration towards a Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity with focus on practices of so-called "conversion therapy" to the 44th Session of the Human Rights Council. https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2019/12/IFTCC-to-UN-HRC-individual-Submission-to-Victor-Madrigal-FINAL-2019-12-21.pdf?x13266

2019-Nov. 17 Contributing author: International Federation for Therapeutic and Counselling Choice Declaration - 2019 (Nov. 17, 2019), https://d3uxejw946d7m5.cloudfront.net/wp-content/uploads/2019/11/IFTCC_Postconference_Statement_2019_English.pdf?x91403

2018-Sept. 21 The American Psychological Association Says Born-That-Way-and-Can't-Change Is Not True of Sexual Orientation and Gender Identity—Updated. https://www.acpeds.org/wordpress/wp-content/uploads/8.21.17-APA-Handbook-Born-That-Way-Not-True-16-9-21-Haynes-Update.pdf

2019-Sept. 16 "Are Religious Californians Really Harming the Mental Health of People Who Identify as LGBTQ?" Essay at Public Discourse. https://www.thepublicdiscourse.com/author/laura-haynes/

2019-May 16 Haynes, L. & Rosik, C.H. "Comment on Proposed Updated APA 'Resolution on Sexual Orientation Change Efforts,'" submitted to the Society for the Psychology of Sexual Orientation and Gender Diversity and the Committee on Sexual Orientation and Gender Diversity that drafted the

	proposed updated position statement on sexual orientation change efforts for the American Psychological Association. 99 pages.
2018 to present	Letters/Fact Sheets to federal, state, county, and city lawmakers and agencies on sexual orientation/gender identity and religious freedom laws and policies. Example: TherapyEquality.org/HarmsOfTherapyBans (periodically updated).
2016-Sept. 27	The American Psychological Association Says Born-That-Way-and-Can't-Change Is Not True of Sexual Orientation and Gender Identity. Published online by professional, religious, ministry, and activist organizations. Example: https://www.therapeuticchoice.com/important-research-articles
2015-2016	(2015-Sept/Oct), (2016-Jan/Feb), (2016-July/August) Letters to the Editor, *The Therapist*, a periodical of the California Association of Marriage and Family Therapists. Urging the Board to end its censoring positions in opposition to therapy that is open to sexual orientation change.