

A young man with short dark hair, wearing a white t-shirt with a red graphic and blue jeans, is sitting on the ground and smiling broadly. He is surrounded by other young people, including a woman in a green shirt on the left and a woman in a black top on the right. They are in front of a building with vertical panels in red, yellow, and grey. The overall atmosphere is positive and social.

ENDING CONVERSION THERAPY IN CHILD WELFARE

NCLR

NATIONAL CENTER FOR LESBIAN RIGHTS

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Introduction

Few practices threaten the mental health of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth more than attempts to change their sexual orientation or gender identity. This so-called "conversion therapy" has been condemned by every major medical and mental health organization in the country, and shown to cause depression, substance abuse, and even suicide.



Children in the child welfare system are vulnerable to being subjected to these efforts by multiple sources: social workers referring youth to mental health providers that engage in conversion therapy; foster parents taking youth to church to help them "pray the gay away"; and placement staff "teaching" youth to dress, talk, or walk in gender conforming ways.

Child welfare agencies can protect youth from these harmful practices through policies that explicitly state that agency representatives—including employees and foster parents—cannot engage in any efforts to change the sexual orientation or gender identity of youth in their care, and that the agency cannot contract with providers who engage in such efforts.

The National Center for Lesbian Rights' Born Perfect Campaign to end conversion therapy has created this toolkit to assist state child welfare agencies in developing these policies.



For further assistance, contact Carolyn Reyes, Youth Policy Counsel & Born Perfect Campaign Coordinator at CReyes@NCLR.org.

Conversion Therapy Fact Sheet

What is conversion therapy?

Conversion therapy, sometimes called “ex-gay therapy,” “reparative therapy,” or “sexual orientation change efforts” is a set of dangerous and discredited practices designed to change a person’s sexual orientation or gender identity. It can take place anywhere from a church basement, to a summer camp, to a mental health professional’s office.

Approximately 698,000 LGBT adults in the U.S. have received conversion therapy at some point in their lives, including about 350,000 who received it as adolescents.¹ The conversion therapy industry most frequently targets youth, as well as families who don’t know what to do when their child comes out to them and look to trusted professionals for help.

What are some examples of conversion therapy?

Historically, conversion therapists have resorted to extreme measures such as institutionalization, castration, and electroconvulsive shock therapy. Other techniques therapists have used include:

- Pairing homoerotic images with nausea, vomiting, paralysis, electric shocks; rubber band snaps, and other forms of punishment
- Using shame to create aversion to attractions to persons of the same sex
- Controlling masturbation with the purpose of changing the cause of sexual arousal

Today, while some counselors still use physical aversive conditioning and even psychotropic medications, the techniques most commonly used include a variety of cognitive techniques such as:

- Training to conform to stereotypical gender norms
- Teaching heterosexual dating skills
- Using hypnosis to try and redirect desires

While these contemporary versions of conversion therapy are less shocking and extreme than some of those more frequently used in the past, they are equally devoid of scientific validity and pose equally serious dangers to patients.

How bad is conversion therapy?

The American Psychological Association has linked conversion therapy to:

- Depression and social withdrawal
- Substance abuse
- Intimate relationship issues
- High risk sexual behaviors
- Loss of faith
- Suicide

The risks are particularly acute for youth, who experience conversion therapy as family rejection.

¹ Christy Mallory, Taylor N.T. Brown and Kerith J. Conron, Conversion Therapy and LGBT Youth (Los Angeles: The Williams Institute, UCLA School of Law), 1-8, <https://bit.ly/2KCITWr>.

What do experts say about conversion therapy?

- Every major medical and mental health association in the country warns that these practices are ineffective, and many condemn them as harmful:

American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Association for Marriage and Family Therapy
American Counseling Association
American Medical Association
American Osteopathic Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
American School Counselor Association
National Association of Social Workers
Pan American Health Organization

- The Religious Institute has found that faith communities can be places of refuge and support where youth who are able to be open about their sexual orientation and gender identity are less likely to consider suicide, and the Youth Suicide Prevention Program has identified positive messages from a supportive faith community as a protective factor for LGBTQ youth.

What is being done to end conversion therapy?

- Since 2012, 14 states (California, New Jersey, Oregon, Illinois, Vermont, Connecticut, Nevada, New Mexico, Rhode Island, Washington, Maryland, Hawaii, New Hampshire, Delaware) and the District of Columbia have passed laws protecting youth under 18 from conversion therapy by licensed mental health professionals. Additionally, dozens of municipalities have passed ordinances protecting youth from these harmful practices. Congress has also introduced a law that would define conversion therapy as fraud.
- Civil rights groups like the National Center for Lesbian Rights and Southern Poverty Law Center are taking practitioners to court for consumer fraud.
- State child welfare and juvenile justice agencies are adopting policies prohibiting staff and contractors from trying to change the sexual orientation or gender identity of youth.
- A coalition of interfaith leaders is taking steps to educate faith communities and congregations about the dangers of these practices.

How can I learn more?

Go to www.nclrights.org/bornperfect or email Carolyn Reyes at CReyes@NCLRights.org.

Professional Policy & Position Statements

Although some mental health providers continue to subject young LGBTQ people to conversion therapy, these practices have been condemned by every major medical and mental health organization in the country:



Just the Facts Coalition



American Academy of Child and Adolescent Psychiatry

Policy Statement on Conversion Therapies (2018)

“The American Academy of Child and Adolescent Psychiatry finds no evidence to support the application of any “therapeutic intervention” operating under the premise that a specific sexual orientation, gender identity, and/or gender expression is pathological. Furthermore, based on the scientific evidence, the AACAP asserts that such conversion therapies (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, conversion therapies should not be part of any behavioral health treatment of children and adolescents. However, this in no way detracts from the standard of care which requires that clinicians facilitate the developmentally appropriate, open exploration of sexual orientation, gender identity, and/or gender expression, without any pre-determined outcome.”

The American Academy of Nursing

Position Statement on Reparative Therapy (2015)

“The American Academy of Nursing strongly supports the position of the Pan American Health Organization (2012) and those of various other professional bodies such as the American Psychiatric Association (2013), American Psychoanalytic Association (2012), American Psychological Association (1975), Anton (2010), International Society of Psychiatric-Mental Health Nurses (2008), National Association of Social Workers (2000), American Medical Association (2014) and the Association of American Medical Colleges (2014) that same-sex sexual relationships between consenting adults are a form of healthy human sexual behavior. The Academy concludes that reparative therapies aimed at curing or changing same-sex orientation to heterosexual orientation are pseudo-scientific, ineffective, unethical, abusive and harmful practices that pose serious threats to the dignity, autonomy and human rights as well as to the physical and mental health of individuals exposed to them.”

American Academy of Pediatrics

AAP Statement from Committee on Adolescence (1993)

“Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation.”

American Association for Marriage and Family Therapy

AAMFT Position on Couples and Families (2009)

“The association does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for [conversion therapy]. AAMFT expects its members to practice based on the best research and clinical evidence available.”

American College of Physicians

LGBT Health Disparities: Executive Summary of a Policy Position (2015)

“The College opposes the use of ‘conversion,’ ‘reorientation,’ or ‘reparative’ therapy for the treatment of LGBT persons. [...] Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons.”

American Counseling Association

Ethical Issues Related to Conversion or Reparative Therapy (2013)

“The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA. The ACA Governing Council passed a resolution in 1998 with respect to sexual orientation and mental health. This resolution specifically notes that ACA opposes portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation. [...] In 1999, the Governing Council adopted a statement ‘opposing the promotion of reparative therapy as a cure for individuals who are homosexual.’ [...]

[T]he ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients. . . This information also must be included in written informed consent material by those counselors who offer conversion therapy despite ACA’s position and the Ethics Committee’s statement in opposition to the treatment. To do otherwise violates the spirit and specifics of the ACA Code of Ethics.”

American Medical Association

Health Care Needs of Gay Men and Lesbians in the United States (1996)

“Aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it.”

American Osteopathic Association

Opposition to the Practice of LGBTQ+ Conversion or Reparative Therapy (2017)

“Therefore be it resolved, that the American Osteopathic Association (AOA) affirms that individuals who identify as lesbian, gay, bisexual, transgender, questioning, identifying as queer, or other than heterosexual (LGBTQ+) are not inherently suffering from a mental disorder; and, be it further resolved, that the AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person’s sexual orientation or gender identity, by licensed medical and mental health professionals; and, be it further resolved, that the AOA supports potential legislation,

regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity, by licensed medical and mental health professionals.; and, be it further resolved, that the AOA opposes the use of sexual orientation change efforts (SOCE), which is based on the assumption that homosexuality is a mental disorder that should be changed; and, be it further resolved, that any effort by an osteopathic physician to participate in any SOCE activity be considered unethical."

American Psychiatric Association

Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies) (2000)

"Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

Therefore, the American Psychiatric Association opposes any psychiatric treatment such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation."

American Psychoanalytic Association

Health Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression (2012)

"As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice. Psychoanalytic technique does not encompass purposeful attempts to convert, repair, change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes."

American Psychological Association

Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts (2009)

"Therefore be it resolved that the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

Be it further resolved that the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

Be it further resolved that the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

Be it further resolved that the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

Be it further resolved that the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

Be it further resolved that the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

Be it further resolved that the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (American Psychological Association, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity."

American School Counselor Association

The Professional School Counselor and LGBTQ Youth (2014)

"The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful.

School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools.”

National Association of Social Workers

Position Statement (2015)

“The stigmatization of LGBT persons creates a threat to the health and well-being of those affected which, in turn, produces the social climate that pressures some people to seek change in sexual orientation or gender identity (Haldeman, D.,1994; HRC, 2015). However, no data demonstrate that SOCE or reparative therapy or conversion therapy is effective, rather have succeeded only in short term reduction of same-sex sexual behavior and negatively impact the mental health and self-esteem of the individual (Davison, G., 1991; Haldeman, D., 1994, APA, 2009).

The NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues believes that SOCE can negatively affect one’s mental health and cannot and will not change sexual orientation or gender identity.”

Pan American Health Organization: Regional Office of the World Health Organization

“Cures” for an Illness That Does Not Exist: Purported Therapies Aimed at Changing Sexual Orientation Lack Medical Justification and are Ethically Unacceptable (2012)

“‘Reparative’ or ‘conversion therapies’ have no medical indication and represent a severe threat to the health and human rights of the affected persons. They constitute unjustifiable practices that should be denounced and subject to adequate sanctions and penalties.”

Just the Facts Coalition (13 National Organizations)

Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel (1999)

“The most important fact about ‘reparative therapy,’ also sometimes known as ‘conversion’ therapy, is that it is based on an understanding of homosexuality that has been rejected by all the major health and mental health professions. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 477,000 health and mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus there is no need for a ‘cure.’”

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World Psychiatric Association

WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviors (2016)

- "1. The World Psychiatric Association (WPA) holds the view that lesbian, gay, bisexual, and transgender individuals are and should be regarded as valued members of society, who have exactly the same rights and responsibilities as all other citizens. This includes equal access to healthcare and the rights and responsibilities that go along with living in a civilized society.

2. WPA recognizes the universality of same-sex expression, across cultures. It holds the position that a same-sex sexual orientation per se does not imply objective psychological dysfunction or impairment in judgement, stability, or vocational capabilities.

3. WPA considers same-sex attraction, orientation, and behavior as normal variants of human sexuality. It recognizes the multi-factorial causation of human sexuality, orientation, behavior, and lifestyle. It acknowledges the lack of scientific efficacy of treatments that attempt to change sexual orientation and highlights the harm and adverse effects of such "therapies".

4. WPA acknowledges the social stigma and consequent discrimination of people with same-sex sexual orientation and transgender gender identity. It recognizes that the difficulties they face are a significant cause of their distress and calls for the provision of adequate mental health support.

5. WPA supports the need to decriminalize same-sex sexual orientation and behavior and transgender gender identity, and to recognize LGBT rights to include human, civil, and political rights. It also supports anti-bullying legislation; anti-discrimination student, employment, and housing laws; immigration equality; equal age of consent laws; and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.

6. WPA emphasizes the need for research on and the development of evidence-based medical and social interventions that support the mental health of lesbian, gay, bisexual, and transgender individuals."

Tips for Developing Child Welfare Policy Prohibiting Conversion Therapy for Youth

- ✓ **Make the policy part of a comprehensive LGBTQ youth policy** that addresses how the agency is promoting a professional environment in which all youth, irrespective of sexual orientation, gender identity and gender expression (SOGIE), are physically and emotionally safe, and treated fairly and respectfully.
- ✓ **In the process of creating policy, include representatives** from the child welfare agency, children's attorneys, Court Appointed Special Advocates, judges, foster parents, group home administrators, community stakeholders, and LGBTQ youth and their families.
- ✓ **Ground the policy explicitly in the child welfare agency's mission and values** and integrate it into the agency's broader objectives.
- ✓ **Make the policy detailed to provide clear guidance on practice issues**, in order to change entrenched behaviors.
- ✓ **Include enforcement provisions** that make clear the responsibility of the agency and contractors to report policy violations by other staff and to promptly intervene to address harassment or other discriminatory behavior by one youth against another youth.
- ✓ **Provide youth with a meaningful, accessible process to grieve violations** of the policy.
- ✓ **Ensure understanding of the policy and its provisions among all relevant professional stakeholders, youth and adults.**
- ✓ **Provide ongoing training to all staff on the policy** with a means to address questions that arise in relation to the policy's implementation.

Examples of Provisions in Child Welfare Policies Prohibiting Conversion Therapy

Illinois Department of Children and Family Services

Support and Well-being of LGBTQ Youths (2009)

“Do not address a youth as deviant, pathological, immoral, or in need of changing because of his or her sexual orientation, gender identity, gender expression, or questioning status or allow a youth to receive services from such providers.

Do not contract or seek treatment services for the purpose of changing a youth’s sexual orientation, gender identity, or gender expression. Such treatment would be ineffective and extremely damaging to the youth’s sense of self and well-being.”

Maryland Department of Human Resources

Working with LGBTQ Youth and Families (2016)

“Staff are prohibited from attempting to convince or coerce an LGBTQ youth to... change their sexual orientation or gender identity.”

New Jersey Department of Children & Families

LGBTQI Policy (2016)

“Referrals are made to community-based providers who demonstrate cultural competence in working with LGBTQI individuals. Individuals who identify as being LGBTQI do not necessarily need counseling or other services. Workers will understand that being LGBTQI does not equate to having a mental illness or the necessity to be referred for mental health services.

Note: In accordance with accepted health care practices and Public Law 2013, c.150 cc (A3371) - Title 45:1-54 and 45:1-55, attempting to change a person’s sexual orientation or gender identity is harmful. CP&P staff does not make referrals to providers or community resources who attempt to change a youth’s sexual orientation or gender identity, (i.e. conversion therapy).”

The City of New York Administration for Children’s Services

Promoting a Safe and Respectful Environment for LGBTQ Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System (2012)

“LGBTQ youth should have access to supportive, inclusive, and nonjudgmental mental health services.

LGBTQ youth should never be subjected to 'reparative' therapy or other interventions designed to change a person's sexual orientation or gender identity.

Under no circumstance is any staff member of Children's Services or its provider agencies to attempt to convince an LGBTQ youth to reject or modify his/her sexual orientation or gender identity. Medical and mental health professional organizations, including the NASW, the APA, the AAP, the AMA, and the ASCA strongly condemn any attempt to 'correct' or change youths' sexual orientation or gender identity through corrective or reparative therapy.

All clinicians must be made aware that nearly every professional organization within the mental health and medical fields, including the NASW and the APA, strongly condemn any attempt to 'correct' or change youth's SOGI through corrective or reparative therapy. Attempts to do so are strictly prohibited by this policy."

Rhode Island Department of Children, Youth and Families

Sexual Orientation, Gender Identity and Expression (2016)

"Department staff or service providers do not disparage or attempt to change a youth's sexual orientation, gender identity or expression.

1. Corrective or reparative therapy is not authorized in any programming supported by the Department.
2. Service providers neither utilize such an approach nor refer youth to any provider or organization that utilizes such an approach."

Tennessee Department of Children's Services

Guidelines for Managing Children/Youth in DCS Custody Related to Sexual Orientation, Gender Identity and Expression (2014)

"In the course of their work, employees, volunteers, and contractors must not refer to youth by using derogatory language in a manner that conveys bias towards or hatred of LGBTI people. In particular, employees, volunteers or contractors must not imply to or tell LGBTI youth that they are abnormal, deviant, or sinful, or that they can or should change their sexual orientation or gender identity.

All LGBTI youth must be provided with access to medical and mental health providers who are knowledgeable about the health care needs of this population. These providers should facilitate exploration of any LGBTI issues by being open, non-judgmental and empathetic, and will not participate in corrective or conversion therapy."

Utah Division of Child and Family Services

Safety for LGBTQ Youth (2017)

“Additionally, staff will recognize that a child’s sexual orientation, gender identity, and gender expression is an integral part of who they are and not a personal ‘choice’ that can be changed or determined by others. Staff will not attempt to convince any child or youth to reject or modify their sexual orientation, gender identity, or gender expression. Staff are prohibited from imposing their personal and/or religious beliefs on children and their families, and will not allow those beliefs to impact the way individual needs of youth or families are met.

In accordance with accepted health care practices, which recognize that attempting to change a person’s sexual orientation, gender identity, or gender expression is harmful, staff will NOT make referrals to mental health providers who attempt to change a child or youth’s sexual orientation, gender identity, or gender expression through conversion, reparative, or regression therapy, or any other methods.”

Vermont Department for Children and Families

Supporting and Affirming LGBTQ Children and Youth (2017)

“Division staff shall not attempt to persuade an LGBTQ individual to reject or modify their sexual orientation, gender identity, or gender expression. Staff will not impose personal or religious beliefs onto children and youth served by the division.”

Model Policy Prohibiting Conversion Therapy

I. Subject

Attempts to Change the Sexual Orientation or Gender Identity of Lesbian, Gay, Bisexual, Transgender, & Queer/Questioning (LGBTQ) and Gender Non-Conforming (GNC) Youth

II. Purpose

LGBTQ youth, who are over-represented in child welfare systems, experience attempts to change their sexual orientation or gender identity as rejection, resulting in increased risk for negative health outcomes, including suicide attempts, depression, and substance abuse. The purpose of this policy is to ensure that all youth have their sexual orientation, gender identity, and gender expression (SOGIE) respected and access to medical and mental health services that affirm their SOGIE and comply with professional standards of care.

III. Policy

A Respectful Behavior and Language

Agency staff and contractors shall not use language—verbal or nonverbal—that demeans, ridicules, or condemns LGBTQ or GNC youth. They shall not imply to or tell youth they can or should change their SOGIE. Nor shall they make any attempts to change a youth's SOGIE.

B Medical and Mental Health Care

In accordance with accepted health care practices which recognize that attempting to change a person's sexual orientation or gender identity is harmful, the Agency/facility shall not employ or contract with medical or mental health providers who attempt to change a youth's sexual orientation or gender identity.

C Training of Agency Staff and Contractors

All Agency staff and contractors shall receive initial and ongoing training on this policy.

D Policy Dissemination to Youth

At the time of intake, staff shall verbally inform all youth about this policy, including the youth's rights and responsibilities under this policy and the procedures for reporting violations. Staff shall provide each youth a copy of the policy [and all other policies related to grievance procedures] during intake. Staff shall provide additional copies of the policy to youth when requested.

E Responsibilities of Agency Staff and Contractors to Respond to and Report Violations

1. All Agency staff and contractors shall be required to report all incidents in violation of this policy in accordance with operating procedures. Failure to report an incident may result in disciplinary or other consequences.

2. Agency staff have an obligation to report conduct by other staff and contractors that may be in violation of this policy to the other individual's supervisor and the [facility] administration.

F Reporting Procedures for Youth

1. The Agency shall ensure that youth are able to report violations of this policy following established grievance procedures, and that grievance procedures protect confidentiality of youth and contain other measures to prevent retaliation.
2. The Agency shall ensure that executive level administrators are informed of all grievances related to violations of this policy irrespective of whether they were resolved to the satisfaction of the youth.

G Enforcement

The Agency shall promptly and effectively respond to grievances filed by youth and shall take swift action according to established procedures when staff or contractors report violations.

IV. Definitions. For the purpose of this policy, the following definitions apply:

Bisexual	Describes a person who is attracted to both men/boys and women/girls.
Gay	Describes a person who primarily is attracted to individuals of the same gender. While historically used to refer specifically to men/boys, it is often used to refer to women/girls attracted to other women/girls as well.
Gender Expression	Describes how individuals communicate their gender to others through hairstyles, clothing, mannerisms, alterations of their body or by choosing a name that reflects their gender identity.
Gender Identity	A person's innate, hardwired, internal sense of being male, female, both, or neither.
Lesbian	Describes a woman/girl who is attracted to other women/girls.
Questioning	People who are unsure of, or in the process of, discovering their sexual orientation or gender identity.
Sex or Gender	A person's actual or perceived sex or gender and is defined by a person's gender identity.

Sexual Orientation

An attraction to others that is shaped at an early age (usually by about the age of 10). Sexual orientation falls on a spectrum that ranges from attraction to only men/boys or only women/girls, to varying degrees of attraction to both men/boys and women/girls, to attraction to neither men/boys nor women/girls.

Transgender

Describes a person whose gender identity differs from the sex they were assigned or presumed at birth. A transgender man/boy is a person who was assigned female at birth, but identifies as and is living as a man/boy. A transgender woman/girl is a person who was assigned male at birth, but identifies as and is living as a woman/girl.

Model Comprehensive LGBTQI Policy with Provisions Prohibiting Conversion Therapy

I. Subject*

Lesbian, Gay, Bisexual, Transgender, & Queer/Questioning (LGBTQ) and Gender Non-Conforming (GNC) Youth

II. Policy Statement

The Agency and contractors shall provide all youth with respectful, fair and equal treatment and access to services, irrespective of the youth's actual or perceived sexual orientation, gender identity, or gender expression (SOGIE). Agency staff and contractors will promote the positive development of all children and youth by demonstrating respect for all children and youth, reinforcing respect for differences, encouraging the development of healthy self-esteem, and helping all children and youth manage the stigma sometimes associated with difference.

III. Purpose

LGBTQ youth are over-represented in child welfare settings and experience higher rates of family rejection, stigma and prejudice than their non-LGBTQ and gender-conforming peers. They are also at increased risk of harassment and physical and emotional abuse while in care. The purpose of this policy is to ensure, consistent with legal obligations and professional standards, that LGBTQ and GNC youth are emotionally and physically safe in care and have equal access to services that are affirming and supportive, including housing, medical and mental health care, and opportunities that promote positive youth development.

IV. Policy

A Non-Discrimination

1. Agency staff and contractors shall not discriminate against or harass any youth based on a youth's actual or perceived SOGIE.
2. Agency staff and contractors shall protect youth from discrimination and harassment by other youth, based on a youth's actual or perceived SOGIE.
3. All services and placements shall be affirming and supportive of youth irrespective of their actual or perceived SOGIE.

B Respectful Behavior and Language

1. Agency staff and contractors shall interact respectfully with youth irrespective of SOGIE.
2. Agency staff and contractors shall not use language – verbal or nonverbal – that demeans, ridicules, or condemns LGBTQ or GNC youth. They shall not imply to or tell youth they can or should change their SOGIE. Nor shall they make any attempts to change a youth's SOGIE.

* NCLR thanks Lambda Legal for their contributions in developing this policy.

3. Agency staff and contractors shall not impose their personal or religious beliefs or those of their institution on LGBTQ and GNC youth, and they shall not allow their personal beliefs to impact the way individual needs of youth are met.
4. Agency staff and contractors shall avoid making assumptions about the SOGIE of youth. Staff and contractors shall use gender-neutral language when communicating with youth and avoid language that presumes all youth are heterosexual, cisgender or gender-conforming. Staff and contractors shall not imply that non-LGBTQ identities are superior or preferable.
5. Agency staff shall defer to youth about the language they use to describe their SOGIE and, generally, utilize terms in the attached glossary. Some youth may not embrace certain terminology or, developmentally, be aware of terminology associated with SOGIE. If youth use an unfamiliar term, staff should respectfully ask what that term means to the youth. LGBTQ terminology changes over time to reflect individuals' identities. The best approach is to talk to one another, listen to how people self-identify, and use language and pronouns that work best for each person.
6. Agency staff and contractors shall use the name and pronoun the transgender or GNC youth specifies, regardless of the name on the youth's identity documents or legal documents associated with any court proceedings. If staff are unsure of the pronouns a youth uses, they should respectfully ask.
7. Assuming the youth has consented, in court reports and other documents, staff and contractors shall refer to youth as *Name (legal name _____) Surname*. Staff shall not use AKA or other abbreviations that have criminal or other negative connotations or use parentheses around the child's chosen name.

C Confidentiality

1. Agency staff and contractors shall not disclose information about a youth's SOGIE to anyone, including the youth's parents, without obtaining the youth's consent, unless disclosure is necessary to comply with state or federal law or required by court order.
2. Agency staff and contractors shall limit disclosure of confidential information related to a youth's SOGIE to information necessary to achieve a specific beneficial purpose.

E Intake and Assessment

1. Agency staff shall ask all youth about their sexual orientation and gender identity and shall not make assumptions based on appearance or stereotypes. Staff shall inform youth of the Agency nondiscrimination policy, that all youth are asked about SOGI, and that the worker is inquiring to ensure their safety and to best meet their needs and provide supportive resources. Staff shall also inform youth of the SOGIE confidentiality policy and grievance procedures regarding discrimination or harassment.
2. If a youth discloses they are LGBTQ, the intake worker shall talk with the youth about it in an open and non-judgmental fashion and determine if the youth has concerns or needs related to being LGBTQ.
3. The intake worker shall refer youth who identify as LGBTQ only to community-based providers who demonstrate competence in working with LGBTQ youth.
4. The intake worker will confer with the youth regarding who in their life is aware of their identity to protect from accidental disclosure.

F Placement

1. Equal and Respectful Treatment
 - a. Placement staff shall apply consistent behavioral standards to all youth.
 - b. Placement staff shall not punish or prohibit behavior that is perceived to defy gender norms.
 - c. Placement staff shall respect the affirmed gender of all youth, including transgender youth, for all purposes.
2. Agency staff shall conduct ongoing check-ins with LGBTQ and GNC youth to confirm that the placement continues to be one that is supportive of the youth's identity and meets their needs.
3. If a caregiver is found to be non-affirming of an LGBTQ and GNC youth, the caseworker shall take immediate action to intervene and take appropriate corrective action.
4. The Agency shall place LGBTQ and GNC youth, like all other youth, in the least restrictive setting appropriate for their needs, and LGBTQ and GNC status is not an indicator, much less justification, to place a child in a more restrictive setting.
5. Agency staff shall place transgender youth consistent with their identity unless that is not the youth's preference. Agency staff shall not automatically place transgender youth according to their sex assigned at birth. Placement decisions for transgender youth are based on the youth's individualized needs and should prioritize the youth's emotional and physical safety, considering the youth's perception of where they will be most secure. If necessary to ensure the transgender youth's privacy and safety, staff shall provide the youth a single room, if available.
6. For non-binary identified youth, staff shall make every effort, consistent with the youth's wishes, to eliminate sex-segregation from placement options.
7. Licensing rules and regulations are not a barrier to placing youth in accordance with their identity. See glossary regarding definition of sex (gender).

G Freedom of Expression

1. Staff shall permit youth to dress and present themselves in a manner consistent with their gender identity and individual expression.
2. Staff shall make and enforce the same grooming rules and restrictions, including rules regarding hair, make-up, shaving, etc., for all youth, regardless of SOGIE status. Staff shall permit transgender and GNC youth to use the approved forms of personal grooming consistent with their gender identity.
3. Staff shall permit youth to use money allocated for clothing and grooming items to select or purchase items that they want and are comfortable with.
4. This rule does not prohibit caregivers from establishing rules regarding appropriateness of certain clothing and grooming items for home, school or other venues, but such rules must be applied consistently for all youth and not imposed to address or target an LGBTQ or GNC youth's freedom of expression.

H Medical and Mental Health Care

1. The Agency shall refer LGBTQ youth for medical and mental health services from LGBTQ-competent providers.

2. The Agency shall ensure, irrespective of identity, that all youth access providers who can have inclusive and affirming conversations regarding sexual health and shall follow all recommendations, including access to contraception and medication for the prevention and transmission of HIV.
3. The Agency shall ensure that transgender youth receive a full medical assessment by qualified medical personnel who adhere to the relevant medical standards of care.
4. The Agency shall provide transgender youth access to necessary transition-related treatment, as determined by qualified medical personnel familiar with the relevant standards of care. Each youth is unique and staff and contractors shall respect whatever decisions a youth makes. There is no right or wrong way to transition.
5. If prior to entering foster care a transgender youth has been receiving transition-related medical care, such as hormone therapy or supportive counseling, the Agency shall continue to provide the youth with access to all transition-related treatments that are medically necessary according to the youth's medical provider and accepted professional standards. The Agency shall ensure hormone therapy continues at current levels pending consultation with the youth's medical provider.
6. In accordance with accepted health care practices which recognize that attempting to change a person's sexual orientation or gender identity is harmful, the Agency shall not employ or contract with medical or mental health providers who attempt to change a youth's sexual orientation or gender identity.

I Strengths and Protective Factors

1. Agency staff shall provide support to families to increase acceptance of their LGBTQ and GNC youth, regardless of whether return home is possible.
2. Agency staff shall connect LGBTQ and GNC youth to LGBTQ community supports and encourage them to participate in LGBTQ community activities.
3. Agency staff shall provide LGBTQ and GNC youth with access to educational, recreational, and other programming and activities that are age- or developmentally-appropriate.
4. Agency staff shall ensure youth have access to reading materials and other age-appropriate information regarding LGBTQ and GNC youth, adults and communities.

J School and Community

1. Agency staff and contractors shall ensure that LGBTQ and GNC youth are safe in their educational settings and connect youth with advocacy necessary to ensure their civil rights are protected.
2. Agency staff and contractors shall inquire whether LGBTQ and GNC youth feel safe and secure in their communities, in transit to services, and when with providers or on community outings.
3. Agency staff and contractors shall ensure that transgender youth are connected with services to address name or gender marker changes, if desired.

K Training of Agency Staff and Contractors

1. All Agency staff and contractors shall receive training on this policy.
2. All Agency staff and contractors shall receive training in providing competent, non-discriminatory, respectful treatment of LGBTQ and GNC youth.

L Policy Dissemination to Youth

At the time of intake, staff shall verbally inform all youth about this policy, including the youth's rights and responsibilities under this policy and the procedures for reporting violations. Staff shall provide each youth a copy of the policy [and all other policies related to grievance procedures] during intake. Staff shall provide additional copies of the policy to youth when requested.

M Responsibilities of Agency Staff and Contractors to Respond to and Report Harassment

1. Agency staff shall promptly and appropriately intervene when a youth physically, verbally, or sexually abuses or harasses another youth based on the youth's actual or perceived sexual orientation or gender identity.
2. All Agency staff and contractors shall be required to report all incidents in violation of this policy in accordance with operating procedures. Failure to report an incident may result in disciplinary or other consequences.
3. Agency staff have an obligation to report conduct by other staff and contractors that may be in violation of this policy to the other individual's supervisor and the [facility] administration.

N Reporting Procedures for Youth

1. The Agency shall ensure that youth are able to report violations of this policy following established grievance procedures, and that grievance procedures protect confidentiality of youth and contain other measures to prevent retaliation.
2. The Agency shall ensure that executive level administrators are informed of all grievances related to policy violations, irrespective of whether they were resolved to the satisfaction of the youth.

O Enforcement

The Agency shall promptly and effectively respond to grievances filed by youth and shall take swift action according to established procedures when staff or contractors report violations.

V. Definitions. For the purpose of this policy, the following definitions apply:

Bisexual	Describes a person who is attracted to both men/boys and women/girls.
Cisgender	Describes a person whose gender identity matches their sex assigned at birth.
Discrimination	Any act, policy, or practice that, regardless of intent, has the effect of subjecting any youth to differential treatment because of that youth's actual or perceived sexual orientation, gender identity, or gender expression.

Gay	Describes a person who primarily is attracted to individuals of the same gender. While historically used to refer specifically to men/boys, it is often used to refer to women/girls attracted to other women/girls as well.
Gender Expression	Describes how individuals communicate their gender to others. People express and interpret gender through hairstyles, clothing, physical expression and mannerism, physical alterations of the body or by choosing a name that reflects their gender identity.
Gender Identity	A person's innate, hardwired, internal sense of being male, female, both, or neither.
Gender Non-Conforming (GNC)	Describes a person whose expression of gender departs from prevailing cultural and social expectations about what is appropriate for their gender.
Harassment	Includes, but is not limited to, name-calling; disrespectful gestures, jokes, or comments; inappropriate touching; threats of physical or emotional acts or negative consequences (including religious condemnation); and physical, sexual or emotional abuse.
Lesbian	Describes a woman/girl who is attracted to other women/girls.
Non-binary	Describes people whose gender is not male or female.
Sex or Gender	A person's actual or perceived sex or gender and is defined by a person's gender identity.
Sexual Orientation	An attraction to others that is shaped at an early age (usually by about the age of 10). Sexual orientation falls on a spectrum that ranges from attraction to only men/boys or only women/girls, to varying degrees of attraction to both men/boys and women/girls, to attraction to neither men/boys nor women/girls.
Transgender	Describes a person whose gender identity differs from the sex they were assigned or presumed at birth. A transgender man/boy is a person who was assigned female at birth, but identifies as and is living as a man/boy. A transgender woman/girl is a person who was assigned male at birth, but identifies as and is living as a woman/girl.

Resources

Survivors can share their stories to inform NCLR's Born Perfect Campaign. Contact Carolyn Reyes at CREyes@NCLRights.org.

Organizational Resources

Human Rights Campaign

The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity

bit.ly/hrcresource

National Center for Lesbian Rights

Born Perfect Campaign

bit.ly/nclrbornperfect

Southern Poverty Law Center

Exposing the Dangers of Conversion Therapy

bit.ly/splcct

The Trevor Project

Conversion Therapy Action Center

<http://bit.ly/trevorprojectct>

Resources for Survivors

Beyond Ex-Gay is a community and resource for those who have survived ex-gay experiences, with information on annual conferences, personal stories, and related media. beyondexgay.com

Parents, Families & Friends of Lesbians and Gays (PFLAG) has local chapters which may be able to connect with parents, youth, and adults who have been impacted by conversion efforts. pflag.org

TrevorSpace is an online community for LGBTQ young people and their friends. trevorspace.org

Truth Wins Out is a non-profit organization that counters anti-gay propaganda, exposes the "ex-gay" myth, and educates the public about gay life. truthwinsout.org

Social Science

American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. 2009. *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. bit.ly/apact2009

National Center for Lesbian Rights and Human Rights Campaign. 2017. *Just As They Are: Protecting Our Children from the Harms of Conversion Therapy*. bit.ly/justastheyare2017

Caitlin Ryan, David Huebner, Rafael M. Diaz and Jorge Sanchez. 2009. *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*. bit.ly/familyrejection2009

Substance Abuse and Mental Health Services Administration. 2015. *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*. bit.ly/samhsa2015

Glossary

Bisexual describes a person who is attracted to both men/boys and women/girls.

Cisgender describes a person whose gender identity matches their sex assigned at birth.

Gay describes a person who primarily is attracted to individuals of the same gender. While historically used to refer specifically to men/boys, it is often used to refer to women/girls attracted to other women/girls as well.

Gender Expression describes how individuals communicate their gender to others. People express and interpret gender through hairstyles, clothing, physical expression/mannerism, physical alterations of their body, or by choosing a name that reflects their gender identity.

Gender Identity A person's innate, hardwired, internal sense of being male, female, both, or neither.

Gender Non-Conforming (GNC) describes a person whose expression of gender departs from prevailing cultural and social expectations about what is appropriate for their gender.

Intersex describes people born with sex chromosomes, external genitalia or internal reproductive systems that are not considered "typical" for either males or females.

Lesbian describes a woman/girl who is attracted to other women/girls.

LGBTQ is an acronym used to describe lesbian, gay, bisexual, transgender and questioning persons, or the community as a whole. The "Q" can also stand for "queer."

Non-binary describes people whose gender is not male or female.

Queer is an umbrella term used to refer to all LGBTQ people; the term can be a political statement as well as an identity, seeking to expand upon limited sexual and gender-based categories. For some, “queer” has a negative connotation, given its historical use as a pejorative term. Many LGBTQ people, however, have reclaimed the word and now use it in a positive light. Many people use the term “queer” because other terms do not accurately describe them.

Questioning individuals are people who are unsure of or in the process of discovering their sexual orientation or gender identity.

Sexual Orientation is an attraction to others that is shaped at an early age (usually by about the age of 10). Sexual orientation falls on a spectrum that ranges from attraction to only men/boys or only women/girls, to varying degrees of attraction to both men/boys and women/girls, to attraction to neither men/boys nor women/girls.

SOGIE is an acronym for sexual orientation, gender identity and gender expression. Everyone has a sexual orientation, gender identity and gender expression.

Transgender describes a person whose gender identity differs from the sex they were assigned or presumed at birth. A transgender man/boy is a person who was assigned female at birth, but identifies as and is living as a man/boy. A transgender woman/girl is a person who was assigned male at birth, but identifies as and is living as a woman/girl.

CONVERSION THERAPY AND LGBT YOUTH



Christy Mallory, Taylor N.T. Brown and Kerith J. Conron

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EXECUTIVE SUMMARY

Conversion therapy is treatment grounded in the belief that being LGBT is abnormal. It is intended to change the sexual orientation, gender identity, or gender expression of LGBT people.¹ Conversion therapy is practiced by some licensed professionals in the context of providing health care and by some clergy or other spiritual advisors in the context of religious practice.² Efforts to change someone's sexual orientation or gender identity are associated with poor mental health,³ including suicidality.⁴ To date, nine states, the District of Columbia, and 32 localities have banned health care professionals from using conversion therapy on youth.

The Williams Institute estimates that:

- 698,000 LGBT adults (ages 18-59)⁵ in the U.S. have received conversion therapy, including about 350,000 LGBT adults who received treatment as adolescents.⁶
- 20,000 LGBT youth (ages 13-17) will receive conversion therapy from a licensed health care professional before they reach the age of 18 in the 41 states that currently do not ban the practice.⁷
- 6,000 LGBT youth (ages 13-17) who live in states that ban conversion therapy would have received such therapy from a licensed health care professional before age 18 if their state had not banned the practice.⁸
- 57,000 youth (ages 13-17) across all states will receive conversion therapy from religious or spiritual advisors before they reach the age of 18.⁹

HISTORY

Conversion therapy has been practiced in the U.S. for over a century. Academic literature has documented instances of conversion therapy being used as early as the 1890s and continuing through the present day.¹⁰ Throughout the history of conversion therapy, a range of techniques have been used by both health care professionals and religious figures seeking to change people's sexual orientation or gender identity. Currently, talk therapy is the most commonly used therapy technique.¹¹ Some practitioners have also used "aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts."¹² Other practitioners have used non-aversive techniques such as attempting to "change

thought patterns by reframing desires, redirecting thoughts, or using hypnosis.”¹³

An estimated 698,000 LGBT adults in the U.S have received conversion therapy either from a licensed professional or a religious advisor or from both at some point in their lives,¹⁴ including about 350,000 LGBT adults who received conversion therapy as adolescents.¹⁵

CURRENT PERSPECTIVES

Professional Health Associations

A number of prominent national professional health associations—including the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics, among others—have issued public statements opposing the use of conversion therapy because it is harmful and ineffective.¹⁶ Several of these associations have called on Congress and state legislatures to pass laws that ban conversion therapy. For example, the CEO of the American Counseling Association (ACA) submitted testimony to the Illinois House and Senate in support of the state’s conversion therapy ban bill in 2015.¹⁷ In addition, ACA members sent 79 letters to the Governor and 84 letters to state legislators in support of the bill.¹⁸ Also, several professional health associations have endorsed the Therapeutic Fraud Prevention Act, a federal bill that would prohibit the practice of conversion therapy, including the National Association of School Psychologists, the American Psychoanalytic Association, the American Counseling Association, and the American Academy of Pediatrics.¹⁹

Public Opinion

Three recent public opinion polls found majority support for ending the use of conversion therapy on youth. A 2017 Gravis Marketing poll found that 71% of Florida residents believed that the use of conversion therapy on youth should be illegal.²⁰ A 2016 Gravis Marketing poll similarly found that 64% of Virginia residents believed that the use of conversion therapy on youth should be illegal.²¹ Another 2016 poll conducted by the Center for Civil Policy similarly found that 60% of New Mexico respondents supported a legal ban on the use of conversion therapy on youth.²² Polling also indicates that many people do not think conversion therapy is effective; only 8% of respondents to a 2014 national poll said they thought conversion therapy could change a person’s sexual orientation from gay to straight.²³

CURRENT LAWS

Conversion Therapy by Licensed Health Care Professionals

As of January 2018, nine states and the District of Columbia had passed statutes limiting the use of conversion therapy: California, Connecticut, D.C., Illinois, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont.²⁴ The laws protect youth under age 18 from receiving conversion therapy from licensed mental health care²⁵ providers and, in some states, other individuals who perform conversion therapy services in exchange for payment.²⁶ California was the first state to pass a conversion therapy ban in

2012.²⁷ Four states—Connecticut, Nevada, New Mexico, and Rhode Island—passed bans in 2017.²⁸ While more limited in reach than the statutory bans, a gubernatorial executive order in New York prohibits the state’s Medicaid program and private health insurers from providing coverage for conversion therapy on youth and prohibits facilities under the State Division of Mental Health from performing conversion therapy on youth.²⁹ In addition, 32 localities in states without statewide bans have passed bans at the local level,³⁰ over half (19) of these localities are in Florida.³¹

All of the state statutory bans allow licensing entities to discipline health care providers who use conversion therapy on youth under age 18.³² Under Connecticut and Illinois laws, the use of conversion therapy on youth is also considered an unfair business practice and the laws allow for enforcement and penalties consistent with other state laws against such practices.³³ In addition, in 2015, a New Jersey court held that providing conversion therapy in exchange for payment constitutes a fraudulent business practice, regardless of whether it is used on youth or adults.³⁴

An estimated 20,000 LGBT youth (ages 13-17) will receive conversion therapy from a licensed health care professional before they reach the age of 18 in the 41 states that currently do not ban the practice, unless additional states pass conversion therapy bans.³⁵ An estimated 6,000 LGBT youth (ages 13-17) who live in states with conversion therapy bans would have received such therapy from a licensed health care professional before age 18 if their state had not banned the practice.³⁶

More states are expected to consider conversion therapy bans in 2018.³⁷ In addition, members of Congress have introduced federal legislation aimed at ending conversion therapy. The Therapeutic Fraud Prevention Act,³⁸ introduced in both the House and Senate in 2017, would classify conversion therapy provided in exchange for payment as a form of consumer fraud.³⁹ The law would allow state attorneys general and the Federal Trade Commission to bring enforcement actions against individuals who are providing conversion therapy for payment or advertising such services.⁴⁰

Conversion Therapy by Religious and Spiritual Advisors

The state statutory conversion therapy bans apply to licensed mental health care providers and sometimes to any others who seek to provide conversion therapy in exchange for payment.⁴¹ The laws generally do not apply to religious or spiritual advisors who engage in sexual orientation or gender identity change efforts within their pastoral or religious capacity. In most states with bans (California, D.C., Nevada, New Mexico, Oregon, Rhode Island, and Vermont⁴²), this means that any individuals (including licensed professionals) may engage in conversion therapy as long as they are acting as clergy or religious counselors and they do not hold themselves out as acting pursuant to a professional license. In states with bans on providing conversion therapy in exchange for payment (Connecticut, Illinois, and New Jersey⁴³), religious or spiritual advisors acting in a pastoral or religious capacity may continue to provide conversion therapy as long as they are not acting pursuant to a professional license and they do not accept payment for their services.

These exclusions for therapy provided by religious or spiritual advisors leave many youth vulnerable to conversion counseling even in states with bans. An estimated 57,000 youth (ages 13-17) across all states will receive conversion therapy from religious or spiritual advisors before they reach the age of 18.⁴⁴

CONCLUSION

Conversion therapy continues to be used in the U.S. despite support for ending the practice among prominent medical and mental health associations and the public. An estimated 698,000 LGBT adults in the U.S. have received treatment to change their sexual orientation or gender identity at some point in their lives, including about 350,000 who received treatment as adolescents. As of January 2018, nine states, the District of Columbia, and 32 localities had enacted laws banning licensed professionals from using conversion therapy on youth. An estimated 20,000 LGBT youth will receive conversion therapy from a licensed professional before they reach the age of 18 in the 41 states that currently do not ban the practice. In addition, an estimated 57,000 LGBT youth across all states will receive conversion therapy from religious or spiritual advisors. Because of the large number of youth who may be vulnerable to conversion therapy, individuals who have contact with minors should be aware that the American Psychological Association has issued a resolution “advising parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth[.]”⁴⁵”

ABOUT THE WILLIAMS INSTITUTE

The Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy at UCLA School of Law advances law and public policy through rigorous, independent research and scholarship, and disseminates its work through a variety of education programs and media to judges, legislators, lawyers, other policymakers and the public. These studies can be accessed at the Williams Institute website.

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ENDNOTES

¹ JUDITH M. GLASSGOLD ET AL., AM. PSYCH. ASSOC., REPORT OF THE AM. PSYCH. ASSOC. TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22 (2009).

² Susan L. Morrow & A. Lee Beckstead, *Conversion Therapies for Same-Sex Attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy*, 32 COUNSELING PSYCHOLOGIST 641, 642 (2004).

³ E.g., Annesa Flentje, Nicholas C. Heck & Bryan N. Cochran, *Sexual Reorientation Therapy Interventions: Perspectives of Ex-Ex-Gay Individuals*, 17 J. GAY & LESBIAN MENTAL HEALTH 256 (2013); Elizabeth M. Weiss et al., *A Qualitative Study of Ex-Gay and Ex-Ex-Gay Experiences*, 14 J. GAY & LESBIAN MENTAL HEALTH 291 (2010); Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumer's Report*, 33 PROF. PSYCH.: RESEARCH & PRACTICE 249 (2002).

⁴ SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016).

⁵ 698,000 US LGBT adults ages 18 to 59 are estimated to have received treatment to change their sexual orientation or gender identity [range 572,000 to 857,000]. This figure was calculated by adding estimates for LGB and transgender adults. In order to determine an estimate for the number of LGB adults who have received conversion therapy, we started with the proportion of LGB adults ages 18 to 59 who report having received treatment to change their sexual orientation (6.7%) from the Generations Study, a national probability study of LGB individuals supported by the Eunice Kennedy Shriver National Institute of Child Health & Human Development of the National Institutes of Health under Award Number R01HD078526 (Ilan H. Meyer, PI). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The proportion who received conversion therapy, across three age cohorts (18-25, 34-41, and 52-59), where receipt of conversion therapy did not statistically significantly differ across these age cohorts, is assumed to be consistent for those ages 26 to 33 and 42 to 51 (Williams Institute unpublished analyses). That proportion was then multiplied by the proportion of adults ages 18 to 59 who identify as LGBT (5.29%) in the 2015-2017 Gallup Daily Tracking Survey (Williams Institute unpublished analyses) and the proportion of LGBT individuals ages 18 to 59 who are cisgender (87.7%) among LGBT-identified respondents to the 2014-2015 BRFSS (Williams Institute unpublished analyses), and then applied to the number of adults ages 18 to 59 in the U.S. (180,757,997), according to 2016 population estimates from the 2010 U.S. Census. For total 18-59 population estimates: search American FactFinder, (last visited Dec. 15, 2017) (select advanced search, enter "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016" under topic or table name, and select "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016" 2016 Population Estimates). The same steps were followed with 95% confidence intervals to calculate a range for each estimate.

In order to determine an estimate for the number of transgender adults who have received conversion therapy, we started with the proportion of transgender adults who report that one or more professionals tried to make them identify only with their sex assigned at birth or try to stop them from being transgender (13.0%), as observed in the U.S. Transgender Survey—the largest purposive sample study of transgender adults to date and reported in JAMES ET AL., *supra* note 4. The proportion who received conversion therapy was multiplied by the proportion of adults ages 18 and older who are estimated to be transgender (0.58%) and then applied to the number of adults ages 18 to 59 in the U.S. (180,757,997). This estimate is likely to be somewhat conservative given that slightly larger proportions of the population identify as transgender among younger age cohorts. For transgender population estimates see ANDREW R. FLORES ET AL., THE WILLIAMS INSTITUTE, HOW MANY ADULTS IDENTIFY AS TRANSGENDER IN THE UNITED STATES? (2016).

⁶ Among adults who have received conversion therapy, approximately 49.9% of LGB adults in the Generations Study and 51% of transgender adults in the U.S. Trans Survey are estimated to have received treatment at or before the age of 18. These proportions are applied to the number of LGB and transgender adults ages 18 to 59 who are estimated to have received conversion therapy, as described above. Thus, we estimate that 350,000 LGBT adults [range 287,000 to 429,000] received treatment as adolescents. We believe that our estimate of conversion therapy among cisgender LGB adolescents is, if anything, an underestimate because the Generations Study survey asked about age at which last conversion therapy was received versus the age at which conversion therapy first began. It is possible that some youth received conversion therapy that did not end until age 18 or later and that these individuals are missing in our estimates of the percentage of LGB youth who received conversion therapy. This would lead to an underestimate of the number of current LGB youth currently at risk of conversion therapy.

⁷ 20,000 LGBT youth ages 13 to 17 [range 13,000 to 32,000] are estimated to live in states without state-wide conversion therapy bans and will receive conversion therapy from a professional before the age of 18. This figure was calculated by adding estimates for LGB and transgender youth. In order to determine an estimate for the number of LGB youth who will receive conversion therapy before age 18, we multiplied the proportion of LGB adults ages 18 to 59 who report having received treatment from a health care professional to change their sexual orientation that began and ended before the age of 18 (1.2%) from the Generations Study (Williams Institute unpublished analyses) by the proportion of youth in grades 9 through 12 who identify as LGB (8.0%) in the 2015 YRBS and by the proportion of LGB young adults ages 18 to 24 who are cisgender (95.7%) among LGBT-identified respondents to the 2014-2015 BRFSS

(Williams Institute unpublished analyses), and then applied this proportion to the number of youth ages 13 to 17 in the U.S. (20,870,650), according to 2016 population estimates from the 2010 U.S. Census. For total 13-17 population estimates: search American FactFinder, (last visited Dec. 15, 2017) (select advanced search, enter “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016” under topic or table name, and select “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016” 2016 Population Estimates). For estimates of the proportion of youth who identify as lesbian, gay, or bisexual see LAURA KANN ET AL., *SEXUAL IDENTITY, SEX OF SEXUAL CONTACTS, AND HEALTH-RELATED BEHAVIORS AMONG STUDENTS IN GRADES 9-12 – UNITED STATES AND SELECTED SITES, 2015* (2016). Note: The proportion who received conversion therapy from a health care professional to change their sexual orientation that began and ended before the age of 18, was not significantly different across the three age cohorts (18-25, 34-41, and 52-59) where receipt of conversion therapy is assumed to be consistent for those ages 26 to 33 and 42 to 51 (Williams Institute unpublished analyses).

In order to determine an estimate for the number of transgender youth who have received conversion therapy we multiplied the proportion of transgender adults who report that a professional (nonreligious or spiritual) tried to make them identify only with their sex assigned at birth or stop them from being transgender (9.0%) by the proportion for whom this had happened at or before age 18 (51%), as observed in the U.S. Transgender Survey and reported in James et al., *supra* note 4. This proportion (4.6%), those who received conversion therapy at or before age 18, was multiplied by the proportion of youth ages 13 to 17 who are estimated to be transgender (0.73%) and then applied to the number of youth ages 13 to 17 in the U.S. (20,870,650). For transgender population proportion estimates see JODY L. HERMAN ET AL., *THE WILLIAMS INSTITUTE, AGE OF INDIVIDUALS WHO IDENTIFY AS TRANSGENDER IN THE UNITED STATES* (2017).

For a list of the states that have banned conversion therapy state-wide see note 24, *infra*. Although some cities and counties have enacted local bans on conversion therapy, the population of these localities is not large and would not have an appreciable impact on state estimates.

⁸ Following the same approach described above, we estimate that approximately 6,000 LGBT youth [range 4,000 to 10,000] live in states that have banned conversion therapy state-wide by licensed professionals.

⁹ 57,000 LGBT youth ages 13-17 [range 37,000 to 94,000] are estimated to be at risk of receiving treatment to change their sexual orientation or gender identity from a religious leader, advisor or counselor at or before age 18. This figure was calculated by adding estimates for LGB and transgender youth. In order to determine an estimate for the number of LGB youth who will receive conversion therapy, we multiplied the proportion of LGB adults ages 18 to 25 who report having received treatment from a religious leader (pastor, religious counselor, priest) to change their sexual orientation that began and ended before the age of 18 (3.4%) from the Generations Study (Williams Institute unpublished analyses) by the proportion of youth in grades 9 through 12 who identify as LGB (8.0%) in the 2015 YRBS and by the proportion of LGB young adults ages 18 to 24 who are cisgender (95.7%) in the 2014-2015 BRFS (Williams Institute unpublished analyses), and then applied this proportion to the number of youth ages 13 to 17 in the U.S. (20,870,650), according to 2016 population estimates from the 2010 U.S. Census. For total 13-17 population estimates: search American FactFinder, (last visited Dec. 15, 2017) (select advanced search, enter “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016” under topic or table name, and select “Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2016” 2016 Population Estimates). For estimates of the proportion of youth who identify as lesbian, gay, or bisexual see KANN ET AL., *supra* note 7.

In order to determine an estimate for the number of transgender youth who received conversion therapy from a religious or spiritual counselor/advisor, we multiplied the proportion of transgender adults who report that such a person tried to make them identify only with their sex assigned at birth or stop them from being transgender (4.0%) by the proportion for whom this had happened at or before age 18 (51%), as observed in the U.S. Transgender Survey and reported James et al., *supra* note 4. This proportion (2.0%), those who received conversion therapy at or before age 18, was then multiplied by the proportion of youth ages 13 to 17 who are estimated to be transgender (0.73%) and then applied to the number of youth ages 13 to 17 in the U.S. (20,870,650). For transgender population proportion estimates see HERMAN ET AL., *SUPRA* NOTE 7.

¹⁰ See, e.g., Prince Morton, *Sexual Perversion or Vice? A Pathological and Therapeutic Inquiry*, 25 J. NERVOUS AND MENTAL DISEASES 237 (1898); William Stekel, *Is Homosexuality Curable?* 7 PSYCHOANALYTIC REVIEW 443 (1930); FRANK S. CAPRIO, *FEMALE HOMOSEXUALITY: A PSYCHODYNAMICS STUDY OF LESBIANISM* 299 (1954); IRVING BIEBER ET AL., *HOMOSEXUALITY: A PSYCHOANALYTIC STUDY* (1962); Jolande Jacobi, *Case of Homosexuality*, 154 J. ANALYTICAL PSYCHOLOGY 48 (1969); Lee Birk, *The Myth of Classic Homosexuality: Views of a Behavioral Psychotherapist in HOMOSEXUAL BEHAVIOR* 376 (J. Marmor, ed., 1980); Robert L. Sptizer, *Can Gay Men and Lesbians Change Their Sexual Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation*, 32 ARCHIVES OF SEXUAL BEHAVIOR 403 (2003).

¹¹ Nat'l Ctr. for Lesbian Rights, #BornPerfect: The Facts About Conversion Therapy, <http://www.nclrights.org/bornperfect-the-facts-about-conversion-therapy/> (last visited Jan. 2, 2018).

¹² GLASSGOLD ET AL., *supra* note 1 at 22.

¹³ *Id.* at 24.

¹⁴ For methodology, see note 5, *supra*.

¹⁵ For methodology, see note 6, *supra*.

¹⁶ American professional organizations that have issued statements opposing the use of conversion therapy on youth include: American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Association for Marriage and Family Therapy, American College of Physicians, American Counseling Association, American Medical Association, American School Health Association, American Psychoanalytic Association, American Psychiatric Association, American Psychological Association, American School Counselor Association, and National Association of Social Workers Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957 (2012); Am. Acad. of Pediatrics, *Homosexuality and Adolescence*, 92 PEDIATRICS 631 (1993); Am. Assoc. for Marriage and Family Therapy, *Positions on Couples and Families: Reparative/Conversion Therapy* (Mar. 25, 2009), http://www.aamft.org/iMIS15/AAMFT/Content/about_aamft/position_on_couples.aspx; Hilary Daniel & Renee Butkis, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 135 (2015); Am. Counseling Assoc., *Ethical Issues Related to Conversion or Reparative Therapy* (Jan. 16, 2013), <https://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy>; Am. Med. Assoc., *Policies on Lesbian, Gay, Bisexual, Transgender & Queer (LGBTQ) Issues, H-160.991 Health Care Needs of the Homosexual Population*, <https://www.ama-assn.org/delivering-care/policies-lesbian-gay-bisexual-transgender-queer-lgbtq-issues> (last visited Dec. 1, 2017); Am. Psychoanalytic Assoc., *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (June 2012), available at <http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender>; Am. Psychiatric Assoc., *Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)* (2000); Barry S. Anton, *Proceedings of the Am. Psychological Assoc. for the Legislative Year 2009: Minutes of the Annual Meeting of the Council of Representatives and Minutes of the Meetings of the Board of Directors*, 65 AM. PSYCHOLOGIST 385 (2010); Am. Psychological Assoc., *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (2009); Am. School Counselor Assoc., *The Professional School Counselor and LGBTQ Youth* (revised 2016), available at https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf; Nat'l Assoc. of Social Workers, *Nat'l Comm. on Lesbian, Gay, Bisexual, and Transgender Issues, Position Statement: Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons* (2015), [https://www.socialworkers.org/LinkClick.aspx?fileticket=yH3UsGQQmYI%3d&portalid=0](https://www.socialworkers.org/LinkClick.aspx?fileticket=yH3UsGQQmYI%3d&portalid=0;);

¹⁷ Press Release, Am. Counseling Assoc., *ACA Advocacy Efforts Assist in Prohibiting 'Conversion Therapy' for Minors in Illinois* (Aug. 21, 2015), available at <https://www.counseling.org/news/news-release-archives/by-year/2015/2015/08/21/aca-advocacy-efforts-assist-in-prohibiting-conversion-therapy-for-minors-in-illinois>.

¹⁸ *Id.*

¹⁹ Press Release, U.S. Rep. Ted Lieu, *Rep. Lieu Introduces the Therapeutic Fraud Prevention Act of 2017*, <https://lieu.house.gov/media-center/press-releases/rep-lieu-introduces-therapeutic-fraud-prevention-act-2017>.

²⁰ Doug Kaplan, *Political Climate Forecast for Florida in 2018 Looks Positive for John Morgan, Negative for Gay Conversion Therapy, and Uncertain on the Future of American Involvement in Syria*, ORLANDO POLITICAL OBSERVER, Apr. 3, 2017, <http://orlando-politics.com/2017/04/13/political-climate-forecast-for-florida-in-2018-looks-positive-for-john-morgan-negative-for-gay-conversion-therapy-and-uncertain-on-the-future-of-american-involvement-in-syria/>.

²¹ Gravis Marketing, *Virginia Election Poll* (May 26, 2017), <http://www.gravismarketing.com/polling-and-market-research/virginia-election-poll052016/>.

²² Ctr. for Civil Policy, *2017 Landscape Poll* (Jan. 15, 2017), <https://civicpolicy.com/2017-landscape-poll/>.

²³ Peter Moore, *Only 8% of Americans Think Gay Conversion Therapy Works*, YOUGOV.COM, June 12, 2014, available at <https://today.yougov.com/news/2014/06/12/gay-conversion-therapy/>.

²⁴ CAL. BUS. & PROF. CODE § 865 (2017); 2017 Conn. Pub. Acts 5 (Reg. Sess.); D.C. CODE § 7-1231.14 (2017); 405 ILL. COMP. STAT. 48/1 (2017); S.B. 201, 79th Leg., Reg. Sess. (Nev. 2017); N.J. REV. STAT. § 45:1-54 (2016); S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017); OR. REV. STAT. §§ 675.070; 675.300; 675.336; 675.540; 675.745 (2016); H. 5277, 2017 Gen. Assem., Reg. Sess. (R.I. 2017); VT. STAT. ANN. tit. 18, § 8351; VT. STAT. ANN. tit. 26, §§ 1354(a), 1842(b), 3016, 3210(a), 3271(a), 4042(a), 4062(a), 4132(a).

²⁵ Some laws apply to other types of health professionals as well. For example, New Mexico's conversion therapy ban applies to nurses and doctors of osteopathic medicine. S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017)

²⁶ See note 24, *supra*.

²⁷ CAL. BUS. & PROF. CODE § 865.

²⁸ 2017 Conn. Pub. Acts 5 (Reg. Sess.); S.B. 201, 79th Leg., Reg. Sess. (Nev. 2017); S.B. 121, 2017 Leg., Reg. Sess. (N.M. 2017); H. 5277, 2017 Gen. Assem., Reg. Sess. (R.I. 2017).

²⁹ Press Release, Gov. Andrew M. Cuomo, Governor Cuomo Announces Executive Actions Banning Coverage of Conversion Therapy (Feb. 6, 2016), available at <https://www.governor.ny.gov/news/governor-cuomo-announces-executive-actions-banning-coverage-conversion-therapy>.

³⁰ In chronological order of passage: Cincinnati, Ohio; Miami Beach, Florida; Seattle, Washington; Wilton Manors, Florida; Miami, Florida; North Bay Village, Florida; West Palm Beach, Florida; Bay Harbor Islands, Florida; Pittsburgh, Pennsylvania; Lake Worth, Florida; Boynton Beach, Florida; El Portal, Florida; Toledo, Ohio; Key West, Florida; Columbus, Ohio; Tampa, Florida; Delray Beach, Florida; Riviera Beach, Florida; Philadelphia, Pennsylvania; Wellington, Florida; Dayton, Ohio; Allentown, Pennsylvania; Greenacres, Florida; Pima County, Arizona; Athens, Ohio; Oakland Park, Florida; Boca Raton, Florida; New York City, New York; Doylestown, Pennsylvania; Reading, Pennsylvania; Palm Beach County, Florida; and Broward County, Florida. Movement Advancement Project, Conversion Therapy Laws, http://www.lgbtmap.org/equality-maps/conversion_therapy (last visited Dec. 4, 2017); North Bay Village, Fla., Ord. No. 2017-004 (enacted Mar. 14, 2017); DELRAY BEACH, FLA., CODE § 133.02 (2017); John McDonald, *Oakland Park Bans Conversion Therapy*, SOUTHFLORIDAGAYNEWS.COM, Oct. 19, 2017, <http://southfloridagaynews.com/Local/oakland-park-bans-conversion-therapy.html>; Brittany Wallman, *Gay-Conversion Therapy Increasingly Outlawed across South Florida*, SUN-SENTINEL.COM, Oct. 13, 2017, <http://www.sun-sentinel.com/local/broward/fl-reg-conversion-therapy-ban-20171012-story.html>; Sklyer Swisher, *Florida County Bans Therapy to Change Kids' Sexual Orientation*, SUN-SENTINEL.COM, Dec. 19, 2017, <http://www.sun-sentinel.com/local/palm-beach/fl-reg-conversion-therapy-finalized-20171219-story.html>; Ted Scouten, *Broward Bans Forced Conversion Therapy for Gay, Transgender Children*, MIAMI,CBSLOCAL.COM, Jan. 9, 2018, <http://miami.cbslocal.com/2018/01/09/conversion-therapy-transgender-gay-children/>.

³¹ *Id.*

³² See note 24, *supra*.

³³ 2017 Conn. Pub. Acts 5 (Reg. Sess.); 405 ILL. COMP. STAT. 48/1 (2017).

³⁴ *Ferguson v. JONAH*, No. L-5473-12 (N.J. Sup. Ct. Dec. 18, 2015).

³⁵ For methodology, see note 7.

³⁶ For methodology, see note 8.

³⁷ *E.g.* H.B. 717, 2018 Leg., Reg. Sess. (Fla. 2017); S.B. 270, 29th Leg., Reg. Sess. (Haw. 2017).

³⁸ H.R. 2119, 115th Cong. (2017); S. 928, 115th Cong. (2017).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ See note 24, *supra*.

⁴² See note 24, *supra*.

⁴³ See notes 24, 33, and 34, *supra*.

⁴⁴ For methodology, see note 9, *supra*.

⁴⁵ Am. Psych. Assoc., Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts, <http://www.apa.org/about/policy/sexual-orientation.aspx> (last visited Dec. 18, 2017).



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PROTECTING OUR CHILDREN FROM
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GLOSSARY OF TERMS

Cisgender

Describes a person whose gender identity aligns with the sex assigned to them at birth.

Gender dysphoria

Clinically significant distress caused when a person's sex assigned at birth is not aligned with their gender identity.

Gender Expression

External manifestation of one's gender identity, usually expressed through behaviors, mannerisms, dress, etc.

Gender Identity

One's innermost sense of self as male, female, a blend of both or neither. A person's gender identity can be the same or different from their sex assigned at birth.

Gender non-conforming (GNC)

Describes a person who does not subscribe to society's traditional expectations of gender expression or gender roles.

Queer

Often used interchangeably with "LGBTQ."

Sexual Orientation

An inherent or immutable enduring emotional, romantic or sexual attraction to other people.

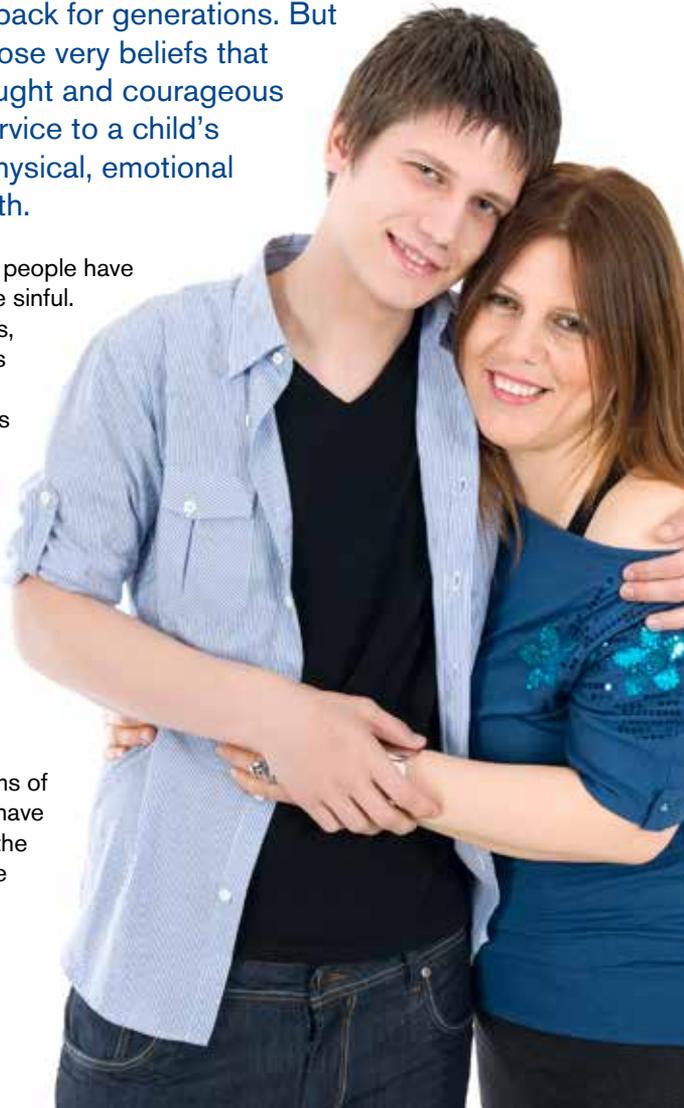
Transgender

Describes people whose gender identity and/or gender expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation.

INTRODUCTION

Parents who learn that their child is lesbian, gay, bisexual, transgender or queer (LGBTQ) embark on a journey that can be both extremely challenging and extremely rewarding. It's a journey fueled by the profound love of a parent for a child but potentially complicated by deep anxiety about that child's future and about questions of morality and religious belief. Families often struggle with closely held ideas that reach back for generations. But it's sometimes those very beliefs that require deep thought and courageous questioning in service to a child's happiness and physical, emotional and spiritual health.

For millennia, LGBTQ people have been told that they are sinful. It happens in churches, synagogues, mosques and temples around the world. (See HRC's *Coming Home* series for information and guidance.) This has prompted the idea that LGBTQ people can also be changed or "converted" to heterosexual or cisgender. (See Glossary of Terms.) In response, various forms of "conversion therapy" have been promoted, with the hope of altering a core component of a person's identity.



We have learned that such attempts simply don't work. Conversion therapy has been condemned as psychologically dangerous by virtually every major medical and mental health organization in the United States. A growing number of states and municipalities are passing laws and regulations to protect children against the practice by licensed mental health professionals.

Nevertheless, the practice continues to destroy lives. Often it exists under the radar and can even occur without the knowledge of parents. Sometimes it's the conscious choice of loving parents who think they're doing what is best for their child but who lack accurate information about its inefficacy and dangers. Often these well-meaning parents choose an option that is destructive to their child and to family relations because they trust practices that are misleadingly labeled as "therapy" or "treatment."

This resource will help parents recognize when and how conversion therapy is promoted, provides information about the dangers of the practice, and offers guidance to parents regarding practices that promote their child's health and well-being.



**WHAT IS
CONVERSION
THERAPY?**

Conversion therapy is any attempt to change a person's sexual orientation or gender identity.

However, because the practice has come under increasing scrutiny, providers frequently change their terminology to avoid detection. Some of those terms can seem relatively harmless at first glance. Here are a few examples:

- sexual orientation change efforts (SOCE)
- sexual attraction fluidity exploration in therapy (SAFE-T)
- eliminating, reducing or decreasing frequency or intensity of unwanted same-sex attraction (SSA)
- reparative therapy
- sexual reorientation efforts
- ex-gay ministry
- promoting healthy sexuality
- addressing sexual addictions and disorders
- sexuality counseling
- encouraging relational and sexual wholeness
- healing sexual brokenness

Proponents of conversion therapy often intentionally conflate the attempted altering of sexual orientation, gender identity or gender expression with the treatment of an actual condition such as sexual addiction. Some claim they are helping clients explore their “sexual fluidity,” or they emphasize that their clients struggle with “unwanted same-sex attractions” or “gender confusion.”



WHAT HAPPENS DURING CONVERSION THERAPY?

Historically, conversion therapists have resorted to extreme measures including institutionalization, castration and electroconvulsive shock therapy. Other techniques therapists have used include:

- Pairing homoerotic images with nausea, vomiting, paralysis, electric shocks, rubber band snaps and other forms of punishment;
- Using shame to create aversion to feelings of attraction to persons of the same sex; and
- Controlling masturbation in a clinical setting with the purpose of changing the cause of sexual arousal.

Today, while some counselors still use physical aversive conditioning and sometimes prescribe psychotropic medications, the practices most commonly used involve “talk therapy” and may include:

- Training to conform to stereotypical gender norms;
- Teaching heterosexual dating skills; and
- Using hypnosis to try to redirect desires.

While these contemporary versions of conversion therapy are less shocking and extreme than some more often used in the past, they are equally devoid of scientific validity and pose serious dangers to patients.

Brandan Robertson, theologian, author and pastor, shared his own experience with conversion therapy when he testified before Colorado’s General Assembly in support of a bill that would protect minors from conversion therapy by state-licensed mental health professionals in that state.¹

“Every week for my entire senior year, I met with this professor who had studied the pseudo-psychology of conversion therapists,” Robertson remembered of his time at Chicago’s Moody Bible Institute. “I would come to my professor’s office and be asked to confess my ‘sinful’ attractions, looking deep into my past to find the periods of abuse that made me gay, and using holy water, crucifixes and intense prayer,

1. Robertson, Brandan, “The Harm Of Conversion Therapy: My Testimony On Colorado House Bill 17-1156,” *HuffPost*, March 2017.

we asked God to heal those wounds and to help me overcome these dangerous same-sex attractions.”

It was the perspective offered by friends outside that experience that made the difference for Brandan. “Being 20 years old at the time, I was able to find a supportive community in Chicago that helped me realize that what I was experiencing in these sessions was not only scientifically unfounded but psychologically harmful,” Brandan told the Colorado legislators. “I was able to maintain some degree of health and eventually come out as an openly LGBT+ evangelical.”

As in Brandan’s case, conversion therapy is often found outside the therapist’s office. It can be practiced in pastoral counseling, in religious youth camps, in addiction treatment facilities, and in prayer and support groups. In extreme cases, it takes the form of “deliverances” or “exorcisms.”

Conversion therapy can also be promoted through self-help books and websites. These might suggest that a person pray to God to become heterosexual or declare that piety will be rewarded with a change in sexual orientation or gender identity.

Regardless of how conversion therapy is practiced, it is ineffective. It is also deeply harmful, victimizing the individual who has been convinced that a core part of their being is unacceptable to God and to the community.



**DOES
CONVERSION
THERAPY
WORK?**

DOES CONVERSION THERAPY WORK?

No. There is no credible evidence that conversion therapy can change a person's sexual orientation, gender identity or gender expression.

At the foundation of conversion therapy theory is the false idea that being LGBTQ is a mental illness that needs to be cured – an idea which has been rejected by every major medical and mental health group for decades. Also underpinning these dangerous practices is the mistaken belief that sexual orientation and gender identity are not inherent elements of a person's identity and are, thus, alterable. These misguided understandings of a person's unchanging core identity has caused unfathomable harm.

In some faith traditions, LGBTQ people are characterized as rebelling against God. They are described as mentally ill or the victims of demonic possession. Their sexual orientation, gender identity or gender expression have been declared the result of an unhealthy relationship with one or both parents or the consequence of abuse. All of these characterizations suggest that LGBTQ identity requires “fixing,” but none of them stand up to scientific scrutiny.



DANGEROUS AND INEFFECTIVE

Conversion therapy has been rejected by virtually every major medical and mental health organization in the United States, including:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American Association of School Administrators
- American Association for Marriage and Family Therapy
- American College of Physicians
- American Counseling Association
- American Federation of Teachers
- American Medical Association
- American Osteopathic Association
- American Psychiatric Association
- American Psychoanalytic Association
- American Psychological Association
- American School Counselor Association
- American School Health Association
- Interfaith Alliance Foundation
- National Association of School Psychologists
- National Association of Secondary School Principals
- National Association of Social Workers
- National Education Association
- Pan American Health Organization (PAHO): Regional Office of the World Health Organization
- School Social Work Association of America

Sources: *Human Rights Campaign, "Policy and Position Statements on Conversion Therapy."*

Just the Facts Coalition, "Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel," 2008.

A HISTORY OF HARM

Despite the claims of its proponents and regardless of what form it takes, conversion therapy has never produced scientifically validated changes in sexual orientation, gender identity or gender expression. It does not eliminate or reduce attractions to persons of the same gender.

Yet, survivors of conversion therapy are often told that their failure to change is due to their own insufficient desire or effort, which creates additional layers of shame and inadequacy and, often, profound depression. Some turn to substances in response. Many report spiritual "numbness," or loss of faith when their prayers do not result in a change of their sexual orientation or gender identity.

Often there is deterioration in family relationships, as conversion therapy participants are taught to blame their parents or are encouraged to believe in non-existent sexual abuse scenarios. Alienation also results when parents or siblings reject an LGBTQ family member because of their inability to change. On the other hand, research has found that family *acceptance* of LGBTQ youth helps promote well-being and aids in protecting against depression, suicidality and use of illegal drugs.

THE HARMS OF CONVERSION THERAPY

The American Psychological Association – along with virtually every major mental health organization – has spoken out against conversion therapy, citing studies that list potential consequences to survivors including:

- Decreased self-esteem and authenticity to others
- Increased self-hatred and negative perceptions of homosexuality
- Confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal and suicidality
- Anger at and a sense of betrayal by conversion therapy providers
- An increase in substance abuse and high-risk sexual behaviors
- A feeling of being dehumanized and untrue to self
- A loss of faith
- A sense of having wasted time and resources
- Self-blame, including feelings of weakness and lack of effort, commitment, faith or worthiness in God's eyes
- Intrusive images and sexual dysfunction

Source: American Psychological Association, "Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation," 2009.

MEANING WELL BUT CAUSING PAIN

Often parents are acting from a place of love and concern when they subject their child to conversion therapy. Their well-meaning efforts might be based in a lack of accurate information about the nature of sexual orientation, gender identity and gender expression. They might be grounded in the particular understanding of scripture or tradition that their religious community promotes and has chosen to live by.

LGBTQ youth who are fortunate enough to be in a position of sufficient independence and self-confidence may muster the strength to reject their parents' desire that they engage in conversion therapy. Some will find allies elsewhere in their own family or among close friends. Most, though, will see the unfortunate outcome of being subjected to these dangerous practices and the negative consequences they bring.

CONVERSION THERAPY AS A FORM OF FAMILY REJECTION

Despite parents' good intentions, LGBTQ youth whose parents attempt to change their sexual orientation or gender identity often experience conversion therapy as a form of familial rejection, which may put them at risk for negative health and mental health outcomes.

LGBTQ young people who experience high levels of family rejection – including sending youth to undergo conversion therapy – are:



8.4x

**MORE LIKELY TO REPORT
HAVING ATTEMPTED SUICIDE**



5.9x

**MORE LIKELY TO REPORT HIGH
LEVELS OF DEPRESSION**



3.4x

MORE LIKELY TO USE ILLEGAL DRUGS



3.4x

MORE LIKELY TO ENGAGE IN UNSAFE SEX

Source: Ryan, C. et al. (2009). *Pediatrics*, vol. 123, no. 1, pp. 346-352; see also, Ryan, C. (2009). *Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children*. San Francisco State University, <http://familyproject.sfsu.edu/publications>



HOPE IN CHANGING TIMES

Happily, a growing number of states and municipalities prohibit the practice of conversion therapy with children under the age of 18 by licensed mental health professionals. At the time of publication, minors are protected from the practice of conversion therapy by licensed mental health professionals in California, Connecticut, the District of Columbia, Illinois, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island and Vermont. Federal courts have rejected challenges to protections in California, New Jersey and Illinois.

In 2013, Exodus International, then the world's largest conversion therapy provider, disbanded and its president issued a formal apology to members of the LGBTQ community and their families. In 2015, former clients of conversion therapy provider JONAH (Jews Offering New Alternatives for Healing) won their suit for fraud in New Jersey state court. In 2016, HRC, the National Center for Lesbian Rights, and the Southern Poverty Law Center filed a consumer fraud complaint with the Federal Trade Commission against People Can Change (now known as Brother's Road), a prominent conversion therapy provider.

THE DANGERS PERSIST

Even if all formal conversion therapy programs were effectively banned, the threat would unfortunately remain. Today, most conversion therapy practices fly under the radar. They take the form of destructive advice from religious leaders or teachers offering "pastoral care." They're found in religious rituals, such as blessings, exorcisms or "deliverances." Small group ministries and discussion groups often promote the need to change one's sexual orientation or gender identity.

Survivors of such abuses often report being coerced or manipulated into participating in conversion therapy. Others sought it out because they had internalized the condemning attitudes of their religious communities or of secular society. Most of them believed that they had to change who they are in order to be loved by God. And all of them experienced psychological and spiritual trauma as a result.



**HOW DO
YOU SPOT IT?**

As knowledge and understanding increase, many religious leaders are beginning to reevaluate their views of the LGBTQ population.

Denominations across many faith traditions now have “open and affirming” or “reconciling” movements that welcome LGBTQ people into full fellowship.

(See HRC’s [Faith Positions](#).)

However, it’s important for LGBTQ individuals and the parents of LGBTQ youth to be on the lookout for teachings and language that is harmful. It’s a good idea to meet with the leader of a faith community before getting involved and to ask questions about the community’s stance on LGBTQ issues.

RED FLAGS RISING

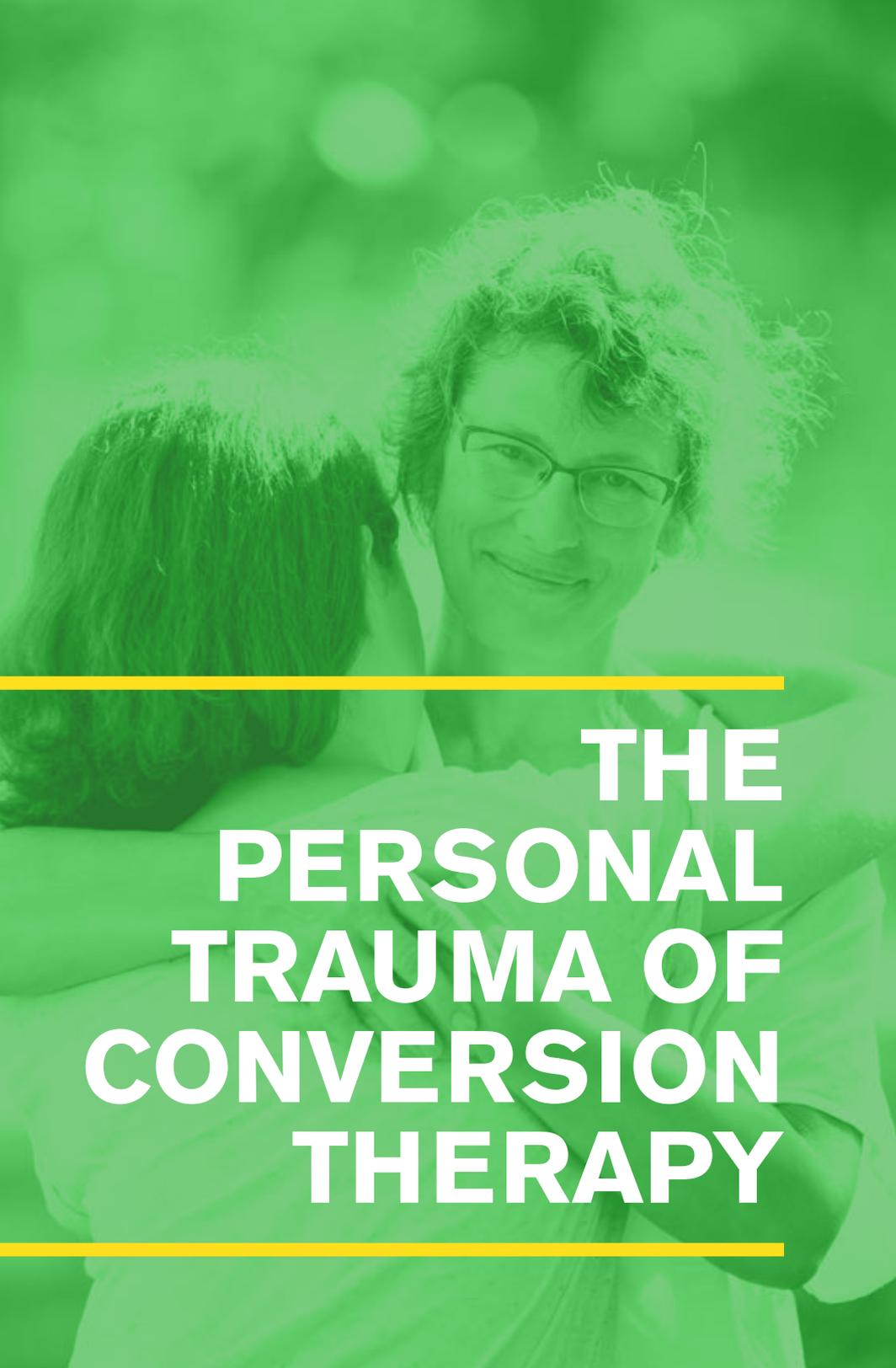
There are clear warning signs that a religious community promotes conversion therapy or relies on its theories. These include:

- Rejection of identifiers like “gay,” “lesbian,” “bisexual” or “transgender” in favor of phrases like “same-sex attraction” or “same-gender attraction”
- Insistence that LGBTQ people not “label themselves” or that acceptance of an LGBTQ identity represents “a distorted view of self”
- Use of phrases such as “struggling with homosexual feelings” or “struggling with same-sex attraction”
- A view of homosexuality as a “habit” or an “addiction”
- Explicit or implicit statements that LGBTQ people need to “align their behavior” with their religious values
- Language about “freedom from homosexuality”
- Language about “sexual and relational wholeness” or about being “broken by sexual and relational sin”
- Presence of brochures published by proponents of conversion therapy, like the Family Research Council or Focus on the Family
- Referrals to conversion therapists, conversion camps or retreats, or support groups providing conversion therapy
- On site “ex-gay ministry,” in the form of “support groups” or other gatherings led by clergy or laity

Church leaders, counselors or religious educators may offer referrals to faith-based youth camps that employ conversion therapy practices. Parents should study camp materials carefully, looking for the red flags listed above.

LGBTQ youth at these camps are often taught that they are an “abomination” to their family, friends, society and God. They’re told that if they try hard enough they can become “normal” people. They are purposefully not told that LGBTQ people across the country enjoy full and happy lives and that many LGBTQ people experience a deep engagement with their faith community.





**THE
PERSONAL
TRAUMA OF
CONVERSION
THERAPY**

While each survivor of conversion therapy has a unique story to tell, there are some common practices employed in attempts to change a core element of a person's identity. The stories below illustrate how a counselor, mentor or pastor working from the false premises of conversion therapy might 1) reject the client's expression of their own emotions or experiences, 2) isolate the client from information that challenges an anti-LGBTQ stance, and 3) ignore the client's right to privacy, employing public shaming as a tool of "therapy."

PERSONAL EXPERIENCE DENIED

From his earliest memories, Mordechai felt that he was different from other boys but found that self-knowledge undermined by a therapist who convinced him he was "delusional," and who named those feelings invalid and untrue. It took years of internal struggle for Mordechai to regain his confidence and his belief in himself.

The first son of a Jewish Orthodox family, Mordechai grew up with a father who was studying to be a rabbi and a mother who was a rabbi's daughter. **"I came out of the womb not what they thought,"** he remembers. **"From the age of two or three I was already very flamboyantly gender non-conforming."**

At Orthodox gatherings Mordechai insisted on sitting on the women's side. He asked for Barbie dolls for his fourth birthday and threw the boyish gifts he received in the garbage. At the age of five, his parents took him to a psychiatrist who encouraged them to compromise when it came to toys but also chipped away at Mordechai's confidence.

Mordecai did well in school and bonded with his father through a common interest in religious study. As he neared puberty, he became aware of his attraction to men and engaged in his first same-sex sexual experimentation at a summer camp. When he confessed to a camp counselor, he was sent to the rabbi and kicked out of the camp. **"It was very traumatic for me and my parents,"** he says. **"I was 11 and I felt like I was being treated as some sort of criminal."**

By the time he entered high school Mordechai had become anorexic. ***“My parents also completely disconnected,”*** he says. ***“They stopped going to parent teacher meetings. They didn’t want to hear the same message again. ‘Your child is smart but different.’”***

He was placed in conversion therapy briefly and returned to it in college, when he began to suffer from depression. ***“I wanted to get married and have children,”*** Mordechai recalls. ***“It becomes a much more self-motivated thing, like ‘I’ve got to get rid of this!’”***

Mordechai began to take sexuality classes and devoured everything in the literature on sexual orientation. At twenty, he finally realized that his sexual orientation would never change. ***“I couldn’t find any expert or person offering the kind of conversion therapy that made sense,”*** he says. ***“It dawned on me that I should probably just surrender myself, that I can’t do anything about it, that I’m just gay.”***

Mordechai turned his energies to creating more supportive resources for LGBTQ individuals in the Jewish Orthodox world, founding Jewish Queer Youth (JQY). ***“It wasn’t till JQY that I started to hear the horror stories of other kids,”*** he says. ***“I was spared the terrible trauma of some conversion therapy stories. Kids would be kicked out of school, be forced to look at AIDS patients and verses in the Bible.”***

He played a role in shutting down JONAH, a Jewish conversion therapy organization that was forced to close in 2015. And he looks to the future with optimism. ***“It’s nice to see the mainstreaming of gender non-conforming and transgender identity,”*** he says. ***“If I had had that opportunity when I was young, it would have been a different journey.”***



ISOLATION FROM ACCURATE INFORMATION

Often the person subjected to conversion therapy has restricted access to accurate information and knows only what is taught by their immediate community. As Lynse became more involved at her church, she was advised not to attend college so she wouldn't be exposed to secular people and their ideas.

When her family moved to Colorado Springs, Lynse, a high school student, joined Ted Haggard's New Life Church. Active in the political right, Haggard frequently preached about "family values" and about marriage being exclusively heterosexual.

Lynse remembers, ***"I knew homosexuality was wrong and if I wanted to be godly I would make efforts to change that about myself."*** She joined a mentorship program, got involved in youth leadership, and sought change through prayer, scripture study and aversive techniques like flicking her wrist with a rubber band every time she felt attractions to women. ***"I was asked not to look at scenes of kissing at the movies,"*** Lynse says. ***"Don't look at it, they kept saying. 'Why would you be interested in being entertained by something that would grieve God?'"***

After graduation, Lynse hoped to study to become a therapist but church leaders advised her to enroll in an internship program at a partner church in Birmingham, Alabama. ***"They said, 'We don't think you're strong enough to go to college. We recommend this first before you go to college, because your faith is not strong enough to handle secular people.'"*** The new environment was highly structured and controlled, including the monitoring of Lynse's web browsing. She was very open with her church leaders and quick to share her struggles. ***"Confessing takes the burden off you but it adds a boatload of shame,"*** she says now.

She also enrolled in a "deliverance ministry" called Cleansing Streams. ***"It covers all the areas of deliverance from alcoholism to abuse"*** Lynse explains. ***"I was put through the homosexuality program 3 or 4 times."*** Around the same time, Ted Haggard was involved in a gay sex scandal and Lynse's own father came out to her as gay, provoking her to question what she had been taught to believe. Church leaders allowed

her to see a therapist on condition that she sign waivers allowing that therapist to report everything to the church.

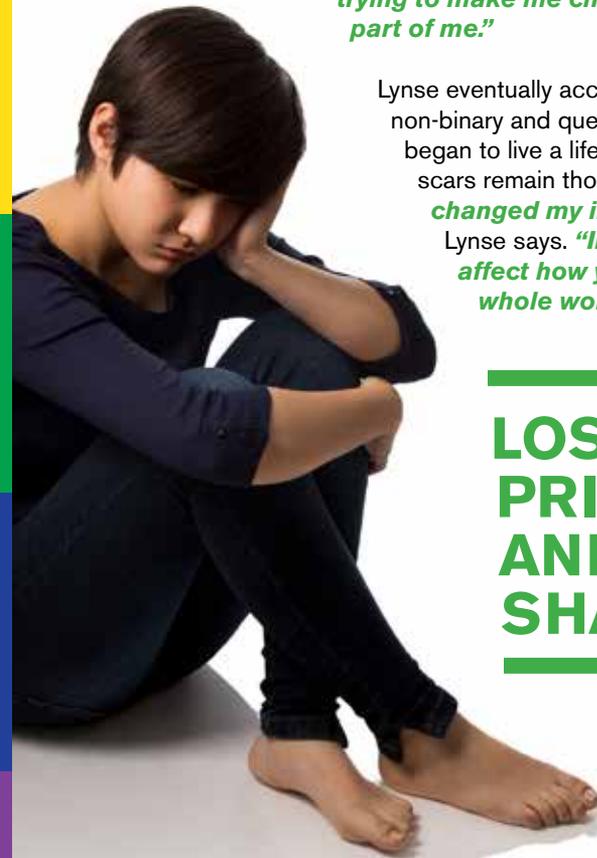
Engaged to be married, Lynse sensed that something was fundamentally wrong with the situation but her mentors insisted she move forward and that “the sex stuff will just work itself out.” The wedding night was emotionally devastating and Lynse knew she had made a mistake. Nevertheless, she tried to make it work and eventually had two children.

After she and her family moved to Portland, Oregon, Lynse had enough distance from the church to reevaluate her choices. **“I went back to therapy, this time with a non-Christian therapist who self-identified as queer,”** she explains. **“She was very much open to whichever decision I made, not leaning me one way. I finally got help that was affirmative, that wasn’t trying to make me change or push aside this part of me.”**

Lynse eventually accepted that she was gender non-binary and queer. She got a divorce and began to live a life that felt more authentic. The scars remain though. **“It has completely changed my interaction with everyone,”** Lynse says. **“Internalized shame can affect how you interact with the whole world.”**

LOSS OF PRIVACY AND PUBLIC SHAMING

For LGBTQ youth – and their parents – the practice of conversion therapy may involve a large number of people having access



to closely held personal information – information that may be used to shame both the youth and their family. Melissa was publicly shamed and then sexually assaulted by two members of her congregation after her bishop leaked information about her sexual orientation.

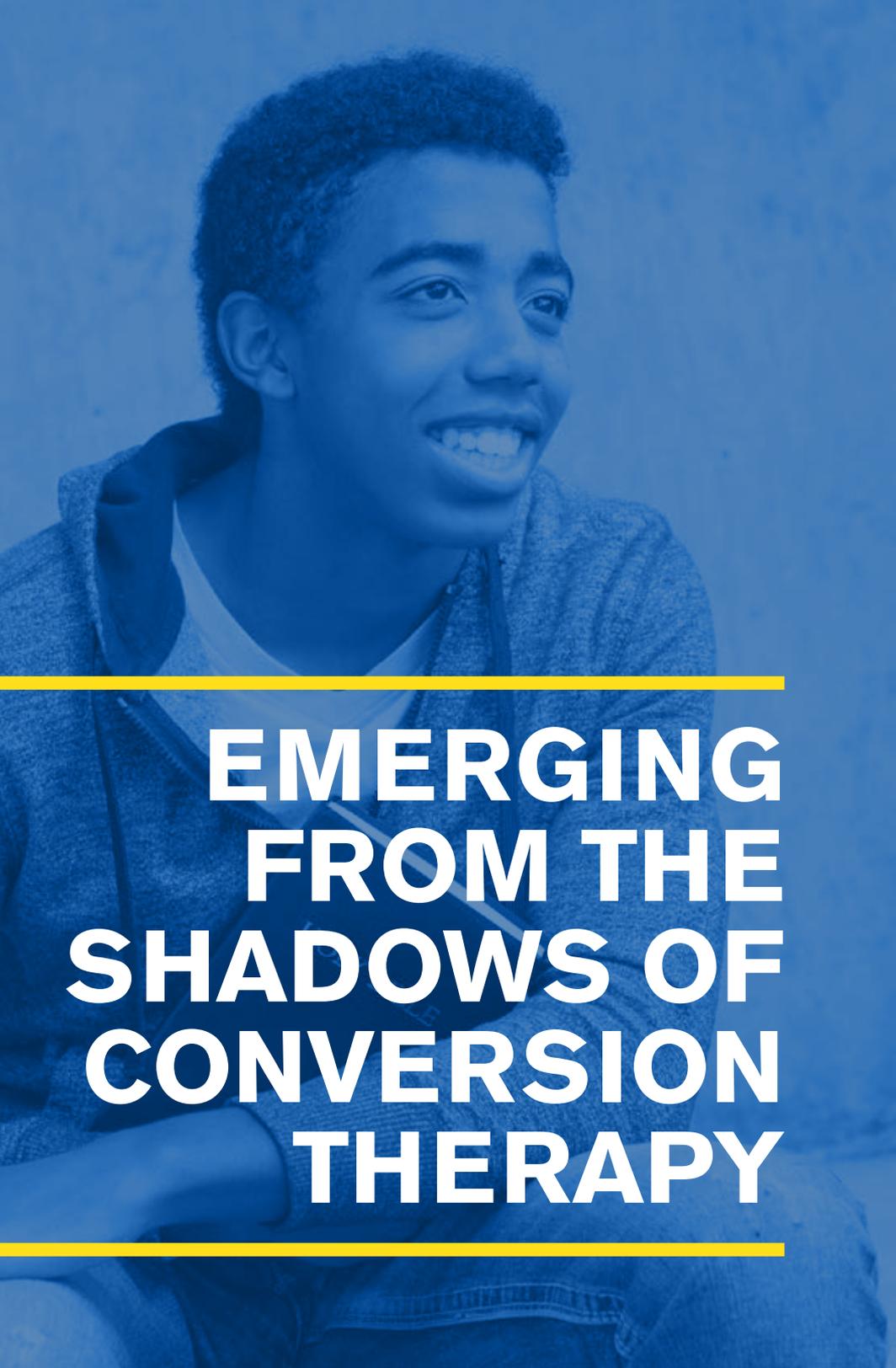
With a religious background that included Jewish, Catholic and Muslim practices, Melissa converted to Mormonism at 14 because she found its teachings about the afterlife especially appealing. When she posed for a photo at a church dance with a girl she had a secret crush on, she was scolded by church leaders because the picture “looked like a couple photo.” A few months later, she was sexually assaulted by two young men who “wanted to make her straight.”

Soon after Melissa confided her concerns about her sexuality to her bishop, she found that an increasing number of people knew that she was a lesbian, possibly through the gossiping of the bishop's wife. The bishop, himself, asked her to fast and pray that the Lord would “take this affliction from her.” Later, the leader of her mission to Argentina promised that if she were faithful enough, she would no longer be a lesbian. **“He told me I would be able to marry a man in the temple and live a righteous life,”** she remembers.

Upon return from her mission and struggling with depression because of her unsuccessful attempts to change, Melissa was referred to Mormon Family Services, where counselors promised they would help her “redirect her thinking.” She didn't realize that the intake papers she signed allowed her therapists to report everything to her bishop, who then leaked personal information to members of her congregation.

When Melissa refused medication meant to control her “impulse problems,” she was dismissed from the program for being uncooperative. Her bishop entreated her to try again. **“He told me there were children waiting to be born to me on the other side,”** she says. When she refused to return to Mormon Family Services, the bishop declared that she had “chosen not to follow the Lord.”

Deeply depressed and sometimes suicidal, Melissa gradually learned of the many other Mormons struggling to reconcile their sexuality with their faith. Eventually she found her way to Affirmation: LGBT Mormons, Families & Friends, which helped her experience a sense of belonging. Her commitment to the Mormon church continues today, but she has stopped trying to change this core element of her being and is focusing on self-acceptance and service to the LGBTQ Mormon community.



**EMERGING
FROM THE
SHADOWS OF
CONVERSION
THERAPY**

Recovery from the trauma of conversion therapy can be a long and difficult process. Each person responds in their own way, drawing on their unique resources. The stories below illustrate how survivors might 1) emerge from their traumatic experiences to take a leadership role that helps others in the same struggle; 2) build a supportive community by reaching out to extended family; 3) embark on a period of introspection and discernment regarding their personal faith journey; and 4) explore new opportunities in communities of faith that are affirming of LGBTQ people.

COMING TO A LEADERSHIP ROLE

Darren was told to quit college and give up his photography business in order to “cure” his homosexuality. He spent years living in a church basement, not allowed to leave without permission from his pastor. Nevertheless, he emerged from those traumatic experiences to live a full life and now serves on the board of The Reformation Project, an LGBTQ-affirming evangelical organization.

Raised Catholic, Darren always struggled with a sense of being different. ***“What I was being taught about bodies and puberty just didn’t seem to apply to me,”*** he remembers. ***“I wanted to be normal just like everyone else.”***

In his teens, he began attending a charismatic, nondenominational church. When an acquaintance threatened to out him after seeing pictures on his computer, Darren responded by coming out. ***“I’m Black, I’m Christian, I’m gay, get used to it,”*** he told people. Friends and church leaders responded with equal strength, telling him that the Bible names homosexuality an abomination.

The soul-searching that followed in Darren’s college years took place among his conservative Christian friends. He explains, ***“I had a born-again, I’m-not-gay-anymore kind of conversion experience.”*** Eventually he became an ordained minister, but received some harsh advice on his first day.

“The pastor of my church pulled me aside and said I should never talk about my homosexuality,” he remembers. ***“I should forget that it ever happened, and I should be ashamed that I ever made that a part of my life. And that started a real cycle of shame that led to compulsive behavior. And in my church, addiction and demonic oppression were one and the same.”***

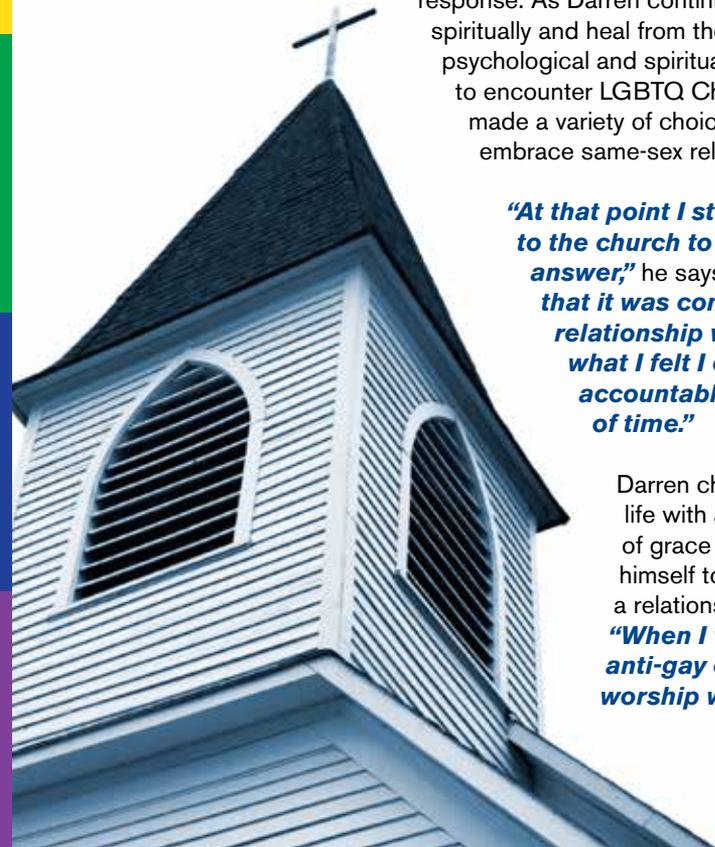
After being robbed at gunpoint after a casual sexual encounter, Darren confessed his sexual behavior to a pastor, who advised an extreme regimen of isolation and religious discipline. The pastor told him to quit school and give up his photography business. Darren lived in the church basement, unable to do anything without the pastor’s approval. He was fasting, losing so much weight that his family became worried.

But he never experienced a change in his sexual orientation and finally recognized he was in an unhealthy situation. He explains, ***“God impressed on me that my Christian belief was true but that everything happening to me was wrong.”***

Darren joined a church that accepted his sexual orientation but that insisted on celibacy as the appropriate response. As Darren continued to grow spiritually and heal from the years of psychological and spiritual abuse, he began to encounter LGBTQ Christians who had made a variety of choices, including to embrace same-sex relationships.

“At that point I stopped looking to the church to give me a single answer,” he says. ***“I realized that it was coming down to my relationship with God and what I felt I could be most accountable to at the end of time.”***

Darren chose to approach life with a greater sense of grace and opened himself to the possibility of a relationship with a man. ***“When I was in those anti-gay churches, my worship was about how***



unworthy I was and how terrible I was and how bad a person I was,” he remembers. ***“It was so focused on me as bad and God as good and how separate and opposite we were. In a church where I was more loved and accepted and had more grace, I finally felt like I could come to God and be seen. Now I could actually bring all of me.”***

Darren offers a powerful reminder to parents, siblings and friends. ***“If you get it wrong with an LGBTQ young person, this can be life and death,”*** he warns. ***“We can already see that this can cause suicide; that there’s higher violence toward LGBTQ people; most of the homeless population are LGBTQ youth. It is so difficult to believe that we are loved as we are. When you have so many people that you trust but that actively condemn, the impact of that is huge. I spent eight years constantly asking the question, ‘Are you with me?’ It took eight years of asking that question to undo eight years of being told I was worthless.”***

FINDING ALLIES IN EXTENDED FAMILY

Latinx and transgender, Malachi experienced rejection from their family and suffered from the conversion therapy practices of their church. (Note: Malachi uses “they/them” pronouns to reflect their gender expression.) They found a champion in an older generation – their own grandmother – and the lesbians in their neighborhood. It was they who helped Malachi recover a sense of self-worth.

Born into a devout Pentecostal family, Malachi was immersed in the faith. Their father was a children’s minister and held weekly church meetings in their home. In junior high, Malachi became aware that their gender expression (masculine) did not align with their sex assigned at birth (female) and faced ridicule and rejection from classmates.

At church, Malachi was exposed to extreme anti-LGBTQ rhetoric, the belief that LGBTQ people would go to hell and the equating of homosexuality with AIDS. They remember a church Halloween party in particular. ***“There was a kind of morality play that portrayed different individuals who died in a variety of ways, such as a construction worker who fell off a beam,”*** they remember. ***“After***

they died, they would get carried away by demons or angels, depending on what kind of life they had lived. I remember a portrayal of a man who died of HIV/AIDS, and he was gay, and when he died, the demons came for him. I remember him screaming and being dragged away.”

In the ninth grade, Malachi's mother said that Jesus told her in prayer that Malachi was a lesbian and possessed by demons. Malachi had one session of individual conversion therapy and one session with a family therapist. ***“During those two sessions I was very suicidal, pretty immediately,”*** Malachi says. ***“That wasn’t a situation I wanted to sit in very long.”***

Malachi's response was a strong one. They came out at school, organized a Gay Straight Alliance, and began to stand up to students who tried to ridicule and bully them. Meanwhile, Malachi's parents began to host PFOX (Parents and Friends of Ex-Gays) meetings at their home and attended meetings of conversion therapy provider Exodus International.

Malachi got support from an elder lesbian in their neighborhood, who allowed Malachi and their friends to use her home as a hangout and as a place to stage poetry readings, make pottery, and play music together. ***“That LGBTQ community lesson around caring for each other across generations has stuck with me to this day,”*** Malachi says.

Malachi turned to other religious traditions, such as the Unitarian Universalist church, for spiritual exploration and support, including theological support that allowed for healthy debates with their father about how homosexuality is presented in the Bible. But the schism between Malachi and their parents continued.

“Homosexuality took over the whole framework of my relationship with my parents,” Malachi says. ***“There was no more parenting. No more looking at a report card or calling a teacher or figuring out a bank account or teaching me how to become a functioning adult. All of that stopped and it became about conversion and religion and gayness and damnation versus salvation.”***

Malachi finally went to live with their grandmother, who offered unconditional love and support. Malachi remembers her saying, ***“The Virgin Mary made you and loves you and I love you. The Virgin does not make mistakes.”***

“That was radical,” Malachi explains. “It was in the name of religion that I was being ostracized and seen as demonic. But it was also in the name of religion that I was seen as holy and worthy of love.”

Over time, their parents began to come around. ***“My parents saw how the majority of parents in PFOX and Exodus lost contact with their kids and that scared them. They moved from you are possessed by demons, to love the sinner hate the sin, to full support.”***

That support grew to the point of walking Malachi down the aisle. ***‘I was healthy enough not to just take care of myself but also love my parents from a healthy distance and support them on their journey all the way to walking me down the aisle at my gay wedding,’”*** Malachi says. ***“This is a story about staying in. A story about a 20 year journey of finding a way back home but more importantly of being brought back into love.”***



ALLOWING TIME FOR GROWTH AND CHANGE

A person in the process of discovering, acknowledging and accepting that they are LGBTQ needs time – and so do their parents. Often both parties are confronting deeply held understandings of scripture and tradition and of the expectations of society. Love for self and for others can be a lifelong journey. For Jason and Roger, moving past the traumatic experience of conversion therapy included a long and careful look at the scriptures they had been taught were condemning of LGBTQ people.

As a child, Jason was traumatized by an exorcism that was intended to rid him of “the demon of homosexuality.” As a young man, his personal study of the Bible convinced him that God loved him just as he was.

A born-again Pentecostal Christian from a large family, Jason grew up in a church where homosexuality was considered the product of demonic possession. When he was twelve, his uncle, a Pentecostal minister, tried exorcising that purported demon. Looking back, Jason believes that his uncle was motivated by compassion as he stood over him with a Bible and “yelled for the demon of perversion to leave me and go back to hell!”

“Part of me was actually excited, because I thought I was going to be ‘healthy and normal,’” he says. By his early twenties Jason had started writing a scripture-based book to try to prove that a person could successfully change their sexual orientation.

He immersed himself in scripture only to emerge with the realization that his assumptions about the Bible being vehemently anti-LGBTQ were entirely unfounded. ***“I meant to write a book to help people come out of being gay,”*** he says. ***“But by the time I ended it was about God being completely fine with who you are!”***

“I’m still 100% a believing Pentecostal,” Jason says. ***“It breaks my heart when so much of the gay community distances themselves from the church or God. I’m so thrilled that many churches are becoming welcoming and affirming.”*** He looks to the future with hope. ***“I’m a gay Christian, so I’m a niche within a niche,”*** he says. ***“But I think that narrow path is gradually widening.”***

READING SCRIPTURE

Holy Scripture – across traditions – has often been interpreted as anti-LGBTQ. A careful study of sacred texts, however, offers a different story. For responsible, theologically sound explorations of the Bible, check out Jay Michaelson’s *God vs. Gay? The Religious Case for Equality* and Matthew Vine’s *God and the Gay Christian*. For a similar exploration of the Qur’an, there’s Scott Siraj al-Haqq Kugle’s *Homosexuality in Islam: Critical Reflection on Gay, Lesbian, and Transgender Muslims* and *Living Out Islam: Voices of Gay, Lesbian, and Transgender Muslims*.

The therapist assigned to Roger by the Mormon church told him that his homosexuality was caused by something that must have happened to him in puberty and could be fixed. He believed it.

Roger's awareness of feeling different from others began early and grew throughout his high school years. His peers began to assume he was gay because of his gender-nonconformity. He angrily denied it when his father confronted him at 14 and began channeling his energies into scholarly and extracurricular pursuits.

His church's teachings on homosexuality were made clear, especially in material presented in its youth programs. Growing up in a Latinx Mormon congregation also had its unique challenges. Roger recalls, ***"There was a lot of machismo. You're told to 'man up.' My dad scolded me for being effeminate. My bishop told me to control my mannerisms, to try not to talk with my hands. I learned that I had to be careful how I walked and how I talked."***

Roger confessed his feelings of same-sex attraction to his bishop, who advised against telling his parents and placed him with a therapist who convinced him that something had happened to him in puberty that caused him to confuse wanting to "be one of the boys" with being attracted to other boys.

When his church put its weight behind California's Proposition 8, which would successfully – and temporarily – reverse marriage equality in the state, Roger joined his parents and volunteered for the cause. ***"I was telling myself, 'This is what God wants,'"*** he remembers. ***"This is what we need to do. I can't give in to my carnal wants."***

With his feelings of attraction to other men still strong, Roger met with another therapist from Mormon Family Services, but this one confessed that his work as a church employee was "out of harmony" with his moral obligation to tell Roger that there was nothing wrong with him. Roger rejected this invitation to healing and enrolled at Brigham Young University (BYU), a Mormon institution.

"I was going to find a wife, get married, everything was going to work out," he says. ***"I felt led to BYU, and I thought God was leading me there to save me, to give me my spouse. But he was leading me there because that was where I was going to find my voice."***

At BYU, Roger connected with other LGBTQ students through student organizations and, later, Affirmation. ***“I connected with other gay Mormons,”*** he explains. ***“I finally accepted myself. I was led to BYU but not for the reasons I thought I was being led there,”*** he says.

The future is bright, but the challenges continue. ***“My mom said she wished she had known,”*** he says. ***“She was upset that the bishop told me not to tell them.”*** His father continues to struggle with the mistaken notion that he failed his son at an early age, when he feels change might have been possible.

“For our parents to come into acceptance they have to mourn the son or the daughter they thought they had,” Roger points out. ***“They have to mourn that loss before they can come to accept it. I think for my dad, he’s still in that mourning.”***

RETURNING HOME OR FINDING A NEW ONE

Many of the individuals whose stories are told here eventually found support and friendship in religious communities that welcome and affirm LGBTQ individuals without requiring them to attempt to change or suppress their sexual orientation or gender identity, to enter into a different-sex relationship or marriage, or to choose celibacy because of their sexual orientation or gender identity. Others remained within their original faith communities, working to enact change and to model the kind of inclusive love that is taught across faith traditions.

Once a devout Muslim, Omar lost faith in God, in Islam, and in religion generally after years of attempting to change his sexual orientation. Gradually, though, he began to pray again, and to explore his Muslim faith from a new perspective.

Born to Pakistani immigrants, Omar was raised by moderately religious Sunni Muslims who taught their children the principles of Islam and upheld its basic moral views. He became more religiously observant while a freshman in college, joining a group that considered “homosexual acts” haram, or condemned by God. Omar was told that celibacy was the only

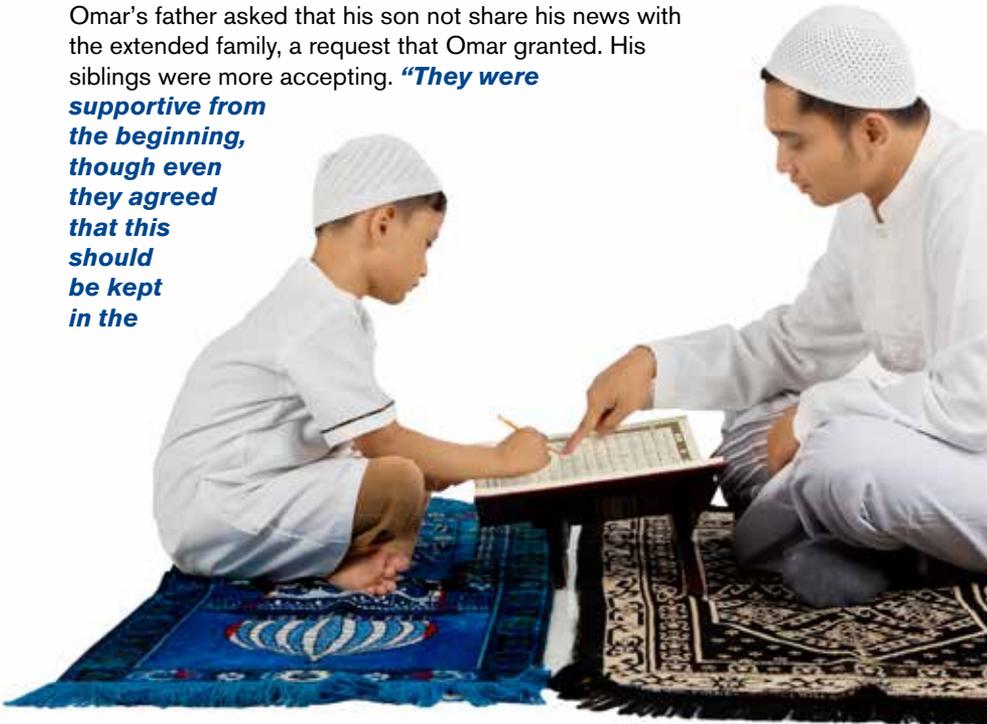
appropriate path for him, and that “the greatest reward in paradise” meant abstaining from “homosexual behavior.”

When he developed a crush on a fellow student, Omar began conversion therapy with Irving Bieber, an author of repudiated works promoting conversion therapy. During his work with Bieber, Omar remembers praying to God **“to help me get back to my heterosexual core, which I believed I had.”** After four years of therapy and of dating women, Omar had experienced no progress in changing his sexual orientation.

“I finally said I think I’m done with this,” he recalls. **“I don’t see it providing any benefit. I’m ready to embrace that I’m attracted to other guys, and that’s not going to change. I’m gay and I should embrace whatever that means.”**

Sharing that new attitude with his family proved a mixed bag. **“My mother was sympathetic at first, but then she spent seven months trying to dissuade me,”** he says. **“You’ll get AIDS,’ she’d say. ‘You’ll never find anybody.’ It was all coming from a place of sheer ignorance.”**

Omar’s father asked that his son not share his news with the extended family, a request that Omar granted. His siblings were more accepting. **“They were supportive from the beginning, though even they agreed that this should be kept in the**



immediate family;” he says. That request soon became a burden. “It conflicted with my desire to express myself openly and not be ashamed or embarrassed or monitor how I talked or what I said at a family gathering.”

Omar's overall experience left him disillusioned with religion and unsure of God's existence. More recently, though, he has found himself praying in moments of need. He has begun a slow return to Islam and to an LGBTQ-affirming belief in God.

“It wasn’t until last year that I became interested in ways to ground myself spiritually,” he says. “I became involved with the Muslim Alliance for Sexual and Gender Diversity (MASGD). We’re a small community but I’ve been active with so many people who have a similar story to mine.” Following the Orlando killings in 2016, Omar and MASGD have worked to educate Americans about Islam and to educate fellow Muslims about the LGBTQ experience.

For guidance on how to remain part of a faith tradition that is not fully welcoming of LGBTQ people – and to explore other options – check out the HRC *Coming Home* series of guides for LGBTQ Muslims, Catholics, Protestants, Mormons and Jews.



**WHAT CAN
YOU DO?**

Parents struggling with the realization that their child is LGBTQ often don't know where to turn, how to best help their child, and how to best help themselves.

Conversion therapy can seem like a clear and easy answer to their problems if they haven't been exposed to accurate information about its inefficacy and dangers. Although parents may find themselves in a place of personal struggle after learning their child is LGBTQ, it is imperative to remember that their decisions about how they respond carry life-long consequences.

Susan Cottrell knows first hand the challenges of being deeply involved in a conservative religious community and learning that her child is LGBTQ.² "I know this can look very scary," she says. "To pull out this one piece about homosexuality – something that you've been taught is a deep sin – can look like the whole pile is going to collapse."

Her advice to parents might seem counterintuitive. She suggests that the best thing to do is to step back. "Let God be God," she says. "God will shake up, deconstruct and reconstruct your faith." Her trust in that process is grounded in a single, core concept. "God is good," she says. "You don't have to be afraid of that. Fear is not from God."

2.Cottrell, Susan, Interview with Norman Allen. Human Rights Campaign. 2017.

WHEN YOUR ADULT CHILD CHOOSES CONVERSION THERAPY

LGBTQ youth who have been raised in the belief that being LGBTQ is a sin often live with the conviction that a core part of their being is unacceptable to God. These youth may choose conversion therapy for themselves when they become adults, hoping to alter their sexual orientation or gender identity. The impossibility of making that alteration, and the continuing belief that they are sinful before God, can lead to depression, despair and even suicide. Parents can – quite literally – save their child's life by helping them accept themselves for who they are.



While Susan suggests that parents “Let God be God,” she, and all those working on behalf of LGBTQ youth, also understand that concrete, affirming steps are necessary. Those steps might include engaging in affirming spiritual counseling and/or psychotherapy; identifying and sharing accurate information; building affirming families; sharing the work with others; and understanding your own faith community and its stance on LGBTQ issues.

SEEK OUT AFFIRMING COUNSELING

For many survivors of conversion therapy, the idea of counseling – whether spiritual or secular – can carry uncomfortable, even frightening implications. However, affirming counseling is available in many denominations that are welcoming and inclusive of LGBTQ members.

Psychotherapy can also be enormously helpful to survivors of conversion therapy and to their families.



Affirming psychotherapists and spiritual counselors support their clients by:

- Accepting LGBTQ identities as normal and positive variants of human experience;
- Accepting and supporting youth as they address the stigma sometimes associated with being LGBTQ;
- Supporting youth as they explore their identities and begin to experience important developmental milestones, such as dating and coming out;
- Reducing family and peer rejection; and
- Increasing family and peer support.³

As a parent, Susan Cottrell found it important to remember that everyone is made in the image of God. “To LGBTQ people who are ashamed of their sexuality, I want to say, ‘God made you the way you are,’” she says. She emphasizes that sexual orientation, gender identity and gender expression are inherent, but that hatred – directed inward or outward – is not.

“You learned or were conditioned to feel loathing,” she explains. “It was not inherent in you to loathe anything about yourself. If you can find a way to get past all the head noise and ask God how *God* sees you, and if you’re able to listen for an answer, you will hear God’s love for you.”

For those who have experienced one of the many forms of conversion therapy, and the hate-filled beliefs that underlie them, such statements can be transformative.



IDENTIFY AND SHARE ACCURATE INFORMATION

Many LGBTQ youth – and their family and friends – view being LGBTQ as intrinsically different from the “normal” human experience. This can have profoundly harmful effects on everyone involved. However, responsible, science-based studies quickly disprove this experience of “otherness.”

It’s of critical importance that parents have access to accurate information about sexual orientation and gender identity and that they share that information with their family. Parents can help their children – all their children – understand that sexual orientation, gender identity and gender expression are real, inherent aspects of every person’s make-up across the spectrum of human experience. Being LGBTQ is just one normal variation on that experience. Check the list of Resources below for a full range of informative opportunities.

BUILD AND STRENGTHEN AFFIRMING FAMILIES

A family that rejects their LGBTQ family members can be the unwitting cause of serious, even life-threatening actions. Parents might feel that responding to a struggling LGBTQ child with love and affection will be understood as condoning behavior. But affection, especially in the midst of a difficult period of discernment, can make all the difference in protecting a child from extreme risks to physical and mental health.

Even as a parent considers how best to respond to learning that their child is LGBTQ, they can listen with an open heart to that child’s struggles, insist on respectful and loving behavior from the rest of the family, and protect their child from bullying and discrimination.

3. Substance Abuse and Mental Health Services Administration, “Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth,” October 2015.

SUPPORTING AND AFFIRMING LGBTQ YOUTH

There are many different ways in which parents and family members can show support for LGBTQ children, which can in turn reduce their risk for health and mental problems and help promote their well-being.

Here are some ways to demonstrate support that fit naturally into most people's lives:

- Create social settings that bring your straight, cisgender and LGBTQ family and friends together.

- Talk openly and honestly with your LGBTQ children about their lives.

- Find opportunities to talk openly with your straight, cis friends about your LGBTQ children, friends and family and the issues they face.

- Make sure to include LGBTQ friends, boyfriends or girlfriends of your child in events and activities just as you would for any other child.

- Don't allow anti-LGBTQ jokes or statements expressed in your presence to go unchallenged.

- Integrate inclusive language into your regular conversations, professional interactions and/or spiritual life.

- Get involved with pro-LGBTQ groups and campaigns and contact your elected officials about equality.

- Join pro-LGBTQ causes or groups on Facebook and through other social networking opportunities.

- Attend pride celebrations and other LGBTQ community events.

- Demonstrate your open support by displaying bumper stickers, mugs, posters, clothing or other similar items.

For further information, please see HRC's [*Coming Out as a Supporter*](#) guide.

SHARE THE BURDEN – AND THE JOY – WITH OTHERS

Just as LGBTQ youth often feel isolated within their religious community, so do the families who are doing their best to support them. A quick online search reveals hundreds – even thousands – of families in the same situation. Organizations such as [Fortunate Families: Catholic Parents of LGBT Children](#) offer a wide range of resources and personal stories. The Human Rights Campaign's bilingual project [A La Familia](#) provides similar resources for the Latinx community. Additionally, [Mama Dragons](#) was founded by the mothers of LGBTQ Mormon children. See Resources below for many more.

KNOW YOUR CHURCH, KNOW YOUR OPTIONS

Sometimes families – including their LGBTQ children – feel there is only one church that offers a true experience of their chosen faith, and that to step away from that particular church is to step away from God. Those who do step away, however, often find themselves immersed in a rich renewal of their faith and a new understanding of God's love for all of creation.

Susan Cottrell and her family made that difficult decision. After she learned of her daughter's sexual orientation, Susan approached a leader at the church and shared her story. "She told me it's a sin and that I can't accept it," Susan remembers. "I told another woman leader in the church and she said the same thing. So we stopped telling people and we left."

After taking a break from church for a period of healing, the Cottrells were ready to try again. "A few years later we found [an inclusive] church," Susan reports. The match proved a good one, and Susan was thrilled. "I really love Jesus and Jesus was the entry point of me to my relationship with God," she says. "And I really love God. But the non-affirming church is too afraid to love the people Jesus told them to love – which is everyone."

Religious communities that provide LGBTQ-positive ministry typically nurture:

- Open and non-stigmatic usage of terms like “lesbian,” “gay,” “bi,” “trans,” “queer,” “LGBTQ;”
- Language inclusive of LGBTQ people, including “you were made in the image of God” or “God loves you as you are”
- Explicit rejection of language about LGBTQ people that they are sick, sinners or in need of healing;
- LGBTQ-affirming interpretation of religious texts;
- An understanding of LGBTQ lives as a normal variation of human experience;
- Accurate information about the harms and ineffectiveness of conversion therapy;
- Promotion of family acceptance of LGBTQ members;
- Referrals to LGBTQ-affirming therapy (both family and individual);
- Symbols of LGBTQ-acceptance, such as the rainbow flag;
- Statements that the community is “open and affirming,” “reconciling” or “LGBTQ affirming;”
- Support for marriage equality, equal access to facilities, programs and activities in accordance with one’s gender identity, and other LGBTQ civil rights;
- A presence at local Pride celebrations.

HRC’s listing of [Faith Positions](#) offers a quick overview of many denominations’ views on LGBTQ issues. Its series of *Coming Home* guides can be helpful in deciding how to work within a chosen faith tradition or begin exploring beyond it. Other resources include The Institute for Welcoming Resources’ publication *All in God’s Family: Creating Allies for Our LGBT families*. See below for many more resources.



CONCLUSION

While the public specter of conversion therapy is fading and responsible community leaders are working to bring about its final demise, the practice continues to create traumatic experiences for LGBTQ youth, casting a shadow across innocent lives – and sometimes resulting in the loss of those lives.

As a parent who has traveled this difficult road, author and faith advocate Susan Cottrell suggests a preemptive strategy that puts scriptural teachings about love at the center of family life. “Your job with these children God has entrusted to you is to love them to the ends of the earth,” she says. “Be the safe place for your child – *whatever* their story.”

The result, she hopes, is that young people will grow up in an environment where they know they are loved unconditionally, and where they can be open with their parents and siblings. For Susan, creating that safe place also means that a child's friends and the wider family – nieces, nephews, aunts and uncles – know there is a place where they are loved and where they can be their true selves. “You just make sure your children are safe and love them and God will bring out the treasure in them.”





RESOURCES

RESOURCES

LGBT-Affirming Religious Organizations

A growing number of religious groups have issued statements officially welcoming LGBTQ as members.

To see where a particular religious denomination stands please visit: www.hrc.org/resources/faith-positions

Believe Out Loud

An online community that empowers Christians to work for justice for lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) people. believeoutloud.com

Institute for Welcoming Resources – National LGBTQ Task Force

A national, ecumenical collaboration of the Welcoming Church Movement working to achieve full acceptance of LGBTQ in the life of the Church. www.welcomingresources.org
info@WelcomingResources.org

Many Voices

A Black church movement for gay and transgender justice, Many Voices envisions a community that embraces the diversity of the human family and ensures that all

are treated with love, compassion, and justice.

www.manyvoices.org
info@manyvoices.org

Soulforce

An interfaith movement working to end the political and religious oppression of lesbian, gay, bisexual, transgender, queer and intersex people through relentless nonviolent resistance.

www.soulforce.org
info@soulforce.org

Faith in America

A non-profit organization whose ultimate goal is to end decades and centuries of using religious teachings to justify marginalizing and discriminating against others. Faith in America is dedicated to influencing media and faith community narratives on religion and sexuality.

www.faithinamerica.org
info@faithinamerica.org

Family Acceptance Project's Faith-Based Training

Faith-based training and resources to help religious leaders, families and congregations to prevent risk and promote well-being for LGBTQ youth.

familyproject.sfsu.edu/
fap@sfsu.edu

GLAAD Religion, Faith and Values Program

A program of GLAAD that works to amplify the voices of LGBT-affirming communities of faith and LGBT people of faith.
www.glaad.org/programs/faithmurray@glaad.org

HRC Religion and Faith Program

A program of the HRC Foundation helping shape a world where no one has to choose between who they are, whom they love and what they believe.
www.hrc.org/religionreligion@hrc.org

PFLAG

Uniting people who are lesbian, gay, bisexual, transgender, and queer (LGBTQ) with families, friends, and allies, PFLAG is committed to advancing equality through its mission of support, education, and advocacy.
www.pflag.org

Religious InSTITUTE

A multifaith organization dedicated to advocating for sexual health, education, and justice in faith communities and society.
www.religiousinstitute.org

Transfaith

A national nonprofit that is led by transgender people and focused on issues of faith and spirituality.
www.transfaithonline.org

Transgender Faith and Action Network – Freedom Center for Social Justice

A collective of trans people of faith who recognize the value of being connected to one another and providing mutual support. TFAAN exists not only to change policies and raise awareness about issues that affect the trans community, but also to provide spaces for trans folks to network and heal.
www.transfaan.com

Please note that no list is fully comprehensive. There are LGBTQ people of faith in a number of religions not listed including Sikhism, Native American religions and others. There also are many LGBTQ people who practice forms of spirituality found outside organized religion.

For More Information about LGBTQ Acceptance and the Dangers of Conversion Therapy

Family Acceptance Project®

The Family Acceptance Project® is a research, intervention, education and policy initiative that works to prevent health and mental health risks for lesbian, gay, bisexual and transgender (LGBT) children and youth, including suicide, homelessness and HIV in the context of their families, cultures and faith communities. FAP uses a research-based, culturally grounded approach to help ethnically, socially and religiously diverse families to support their LGBT children.
familyproject.sfsu.edu/

Human Rights Campaign

Being supported at home, in school and in the community is important for all children and youth – especially LGBTQ youth. From creating an inclusive learning environment for students – whether a student is in the process of transitioning or has two moms – to understanding the challenges and resiliency of LGBTQ youth, HRC provides a wealth of resources for supporting LGBTQ youth.

www.hrc.org/explore/topic/children-youth

and

www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy

National Center for Lesbian Rights

In June 2014, NCLR launched #BornPerfect: The Campaign to End Conversion Therapy by passing laws across the country to protect LGBTQ children and young people, fighting in courtrooms to ensure their safety, and raising awareness about the serious harms caused by these dangerous practices.

www.nclrights.org/our-work/bornperfect/

If someone is trying to change your child's sexual orientation or gender identity, contact the National Center for Lesbian Rights at **BornPerfect@nclrights.org** or **1-800-528-6257** to explore your legal options.

Southern Poverty Law Center (SPLC)

People who have undergone conversion therapy have reported increased anxiety, depression, and in some cases, suicidal ideation. Conversion therapy can also strain family relationships, because practitioners frequently blame a parent for their child's sexual orientation.

Through litigation, education and advocacy, SPLC works to expose and stop this harmful practice.

www.splcenter.org/issues/lgbt-rights/conversion-therapy

Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services)

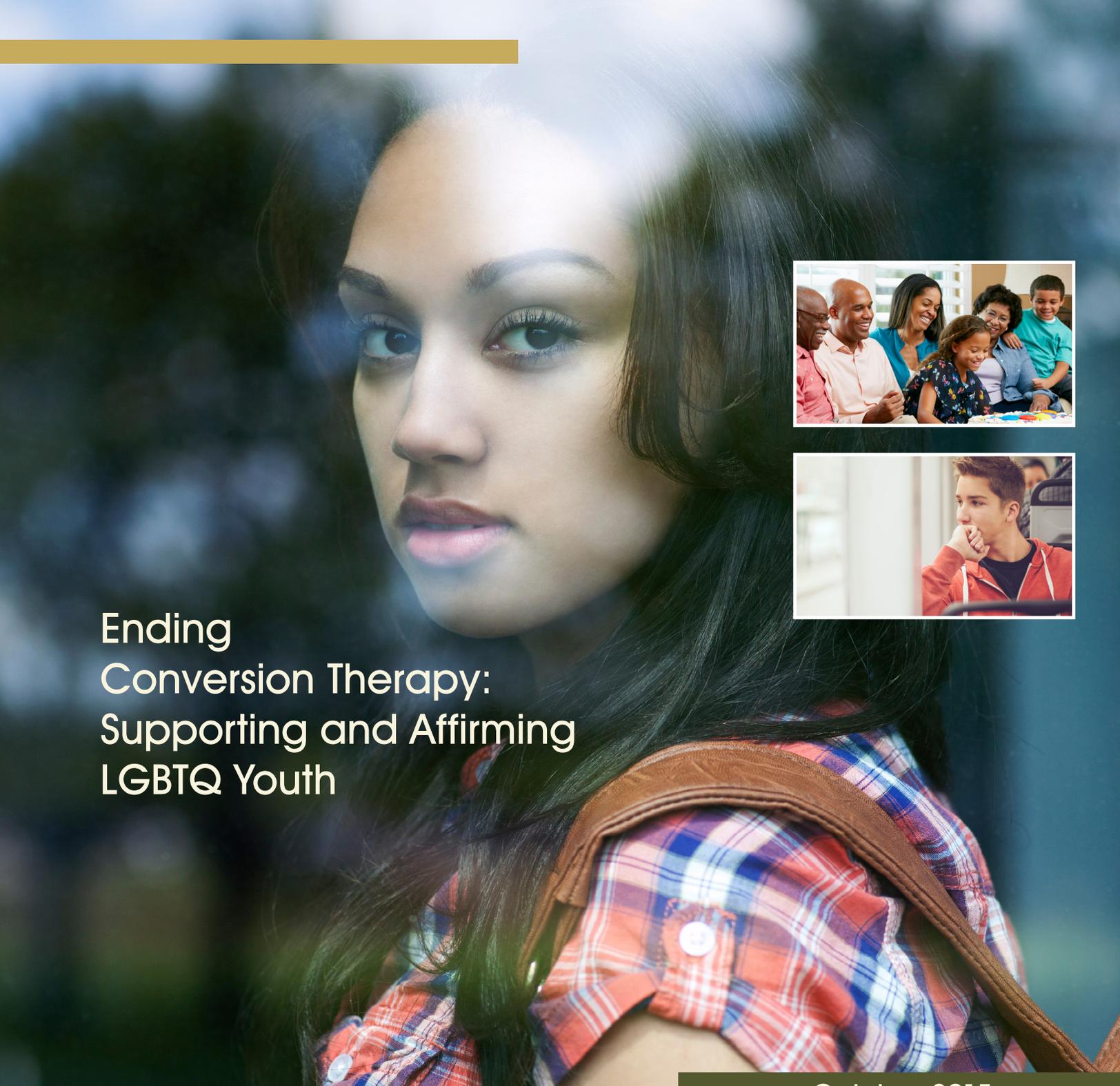
(October 2015) *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* store.

samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf

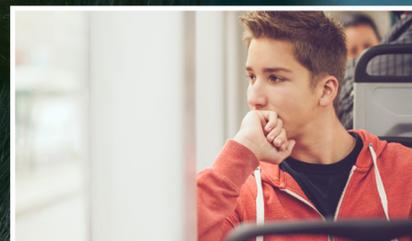


**HUMAN
RIGHTS
CAMPAIGN**
FOUNDATION™

1640 Rhode Island Ave., N.W.
Washington, D.C. 20036-3278



Ending
Conversion Therapy:
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LGBTQ Youth



October 2015





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Executive Summary

Lesbian, gay, bisexual, and transgender youth, and those who are *questioning* their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's LGBTQ identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority*¹ youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression²—is a practice that is not supported by credible evidence and

has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender³sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the

assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood

(Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

Therapeutic Efforts with Sexual and Gender Minority Youth⁴

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches

include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

Ending the Use of Conversion Therapy for Minors

Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

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Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual’s sexual orientation, gender identity, or gender expression⁵—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights [areas of opportunity for future research](#), and provides an overview of [mechanisms to eliminate the use of harmful therapies](#). In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: [Family and Community Acceptance](#),

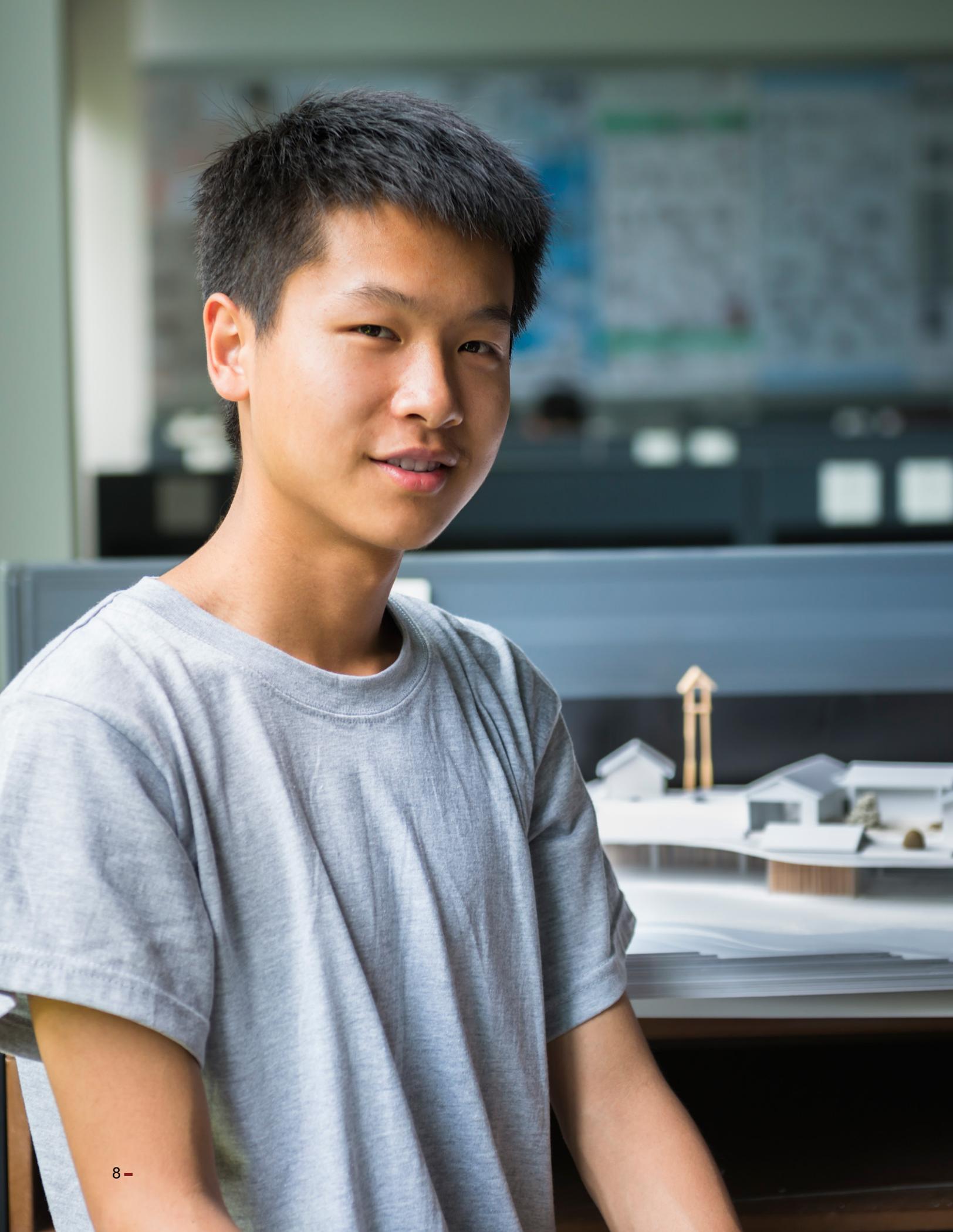
“Being gay is not a disorder. Being transgender is not a malady that requires a cure.”

—Vice Admiral Vivek H. Murthy,
19th U.S. Surgeon General

[School-Based Issues](#), [Pediatric Considerations](#), and [Affirmative Exploratory Therap](#). In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population

SAMHSA’s mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.⁶As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.



Professional Consensus Process

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B.

Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would constitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.



“PFR” created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Statements of Professional Consensus

The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals' work in this area.

Guiding Principles

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of “self-determination” requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of “justice” and “beneficence and nonmaleficence” require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional Consensus on Conversion Therapy with Minors

1. Same-gender⁷sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.
5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in pre-pubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics⁸, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

Research Overview

Sexual Orientation

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalytic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)⁹.

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth¹⁰. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or

male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression¹¹(American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned at birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuyper, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well as distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited

research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder¹²(APA Task Force on Gender Identity and Gender Variance, 2009). Though there

have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic

criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories¹³: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender

typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014). Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)¹⁴. Compared to earlier cohorts, today's sexual minority adolescents are developing an awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or "coming out" as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

Clinical Issues in Adolescence

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic

in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)¹⁵. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing

not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar,

2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities – may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005)). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity.

Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school

from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the over-representation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where

sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore,

important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, & Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction¹⁶

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment¹⁷:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to

change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting

& Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria

(Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting

behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families¹⁸

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding. A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health

and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-appropriate milestones and facilitating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and lives of *lesbian, gay, bisexual, transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and

adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link

between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader principles and

concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral

health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further, behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual

and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that

adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone

therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disciplinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescent's gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of

hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal

of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults, withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options

related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mammoplasty beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

Future Directions for Research

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for

more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identity among youth.

Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.
- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and

how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, [stating in part](#):

“When assessing the validity of conversion therapy, or other practices that seek to change an individual’s gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.

As part of our dedication to protecting America’s youth, this Administration supports efforts to ban the use of conversion therapy for minors.” (Jarrett, 2015)

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“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Approaches to Ending the Use of Conversion Therapy

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
 - Adoption of public policies that end discrimination
 - Increasing access to health care
 - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
 - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
 - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
 - Inclusion of affirmative information and treatment models in professional training curriculum
 - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts
 - State and federal legislation that bans sexual orientation and gender identity change efforts
 - Federal and state regulatory actions and additional Administration activities
 - Legal action

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,¹⁹ including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the “Don’t Ask, Don’t Tell” policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;
- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the “It Gets Better” Project, which aims to give LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more

accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.²⁰

Dissemination of information, training and education for behavioral health providers

The major health associations have issued policy statements critical of conversion therapy including the [World Health Organization](#), the [American Medical Association](#), the [American Academy of Pediatrics](#), the [American Academy of Child and Adolescent Psychiatry](#), the [American Psychological Association](#), [American Counseling Association](#), [American Psychoanalytic Association](#), and the [National Association of Social Workers](#), among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.²¹

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*. As part of this publication, the association indicates that “doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by [...] identifying various harmful practices (e.g., historical practice of using

‘reparative’ therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients.”

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.

Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of “*Do No Harm*” through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people’s dignity.

Legislative, regulatory, and legal efforts

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.

- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.²³

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."²⁴



Guidance for Families, Providers, and Educators

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*). Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

Promoting Family and Community Acceptance and Support

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of “connectedness” has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been

shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

Key Points:

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent’s sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child’s gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child’s overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.
- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child’s sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent’s identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child “fit in,” have a good life and be accepted by others. The Family Acceptance Project’s research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family’s cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual’s dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child’s risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don’t have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child’s well-being - without “accepting” an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child’s experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child’s safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

Resources

Family Acceptance Project: <http://familyproject.sfsu.edu/>

Gender Spectrum: www.genderspectrum.org

Institute for the Study of Sexual Identity: www.sexualidentityinstitute.org

PFLAG: www.pflag.org

References

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press

Centers for Disease Control and Prevention. (2009). *Strategic direction for the prevention of suicidal behavior: Promoting individual, family, and community connectedness to prevent suicidal behavior*. Atlanta, GA: Retrieved from www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf.

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*, 50(4), 453–470.

Ryan, C. (2009). Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524

Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x

Seil, K. S., Desai, M. M., & Smith, M. V. (2014).

Sexual orientation, adult connectedness, substance use, and mental health outcomes among adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health*, 104(10), 1950-1956.

Substance Abuse and Mental Health Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. (HHS Publication No. PEP14-LGBTKIDS). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from <http://store.samhsa.gov/product/PEP14-LGBTKIDS>.

Bullying, Harassment, and Other School-Based Issues

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise

mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the

context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.

- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH): www.cdc.gov/HealthyYouth/

GLSEN: www.glsen.org

Human Rights Campaign, Welcoming Schools Initiative: www.welcomingschools.org

National Center for Lesbian Rights, Youth Project: www.nclrights.org/our-work/youth

National Association for School Psychologists, Committee on GLBTQ Issues: www.nasponline.org/advocacy/glb.apsx

PFLAG : www.pflag.org

Safe & Supportive Schools Project: <http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx>

References

American Psychological Association & National Association of School Psychologists. (2014). Resolution on gender and sexual orientation diversity in children and adolescents in schools. Retrieved from http://www.nasponline.org/about_nasp/resolution/gender_sexual_orientation_diversity.pdf

Fisher, E., & Komosa-Hawkins, K. (Eds.). (2013). *Creating safe and supportive learning environments a guide for working with lesbian, gay, bisexual, transgender, and questioning youth, and families* (1 ed.). London: Routledge.

National Association of School Psychologists. (2014). NASP Position statement: Safe schools for transgender and gender diverse students, from http://www.nasponline.org/about_nasp/positionpapers/Transgender_PositionStatement.pdf

Orr, A., Baum, J., Gill, E., Kahn, E., & Salem, A. (2015, August). Schools in transition: A guide for supporting transgender students in K-12 schools, from <http://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf>

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46(6), 1580-1589. doi: 10.1037/a0020705

U.S. Department of Education. (2014). Questions and answers on Title IX and sexual violence, from <http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf>

U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S.

“When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl’s clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression. Thankfully, one of my friends recognized the warning signs and called social services, which intervened and got me the housing and medical care I needed. It is always darkest before the dawn, but I’m living proof that a smart bystander can save a life.”

—Amy

Department of Justice, Civil Rights Division, from <http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf>

Pediatric Care Considerations for LGBTQ Children and Adolescents

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond

to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.

- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral

health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

- American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, 132(1), 198 -203 doi: 10.1542/peds.2013-1282
- Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

References:

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>

“ Having my family reject me because I’m trans broke my heart into more pieces than I could have imagined. Even more painful was the feeling they no longer loved or valued me. Having my Grandmother take me in restored my belief in love. To have her arms to fall into meant that I no longer was alone, that death did not seem like the only road to stability, comfort, and joy. That perhaps I should build a future because I again had someone to help me do so and enjoy it with me.”

—Malachi

Affirmative Care for Gender Minority Youth

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child’s developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524

Here are a few key points to keep in mind when considering a supportive and balanced approach for transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender non-conforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy **and** a psychological/readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.
- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or implicitly make an adolescent feel “stuck” in a gender identity.
- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.

- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider’s input is valued and perceived as equally critical to the care of the individual patients served.

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

PFLAG Transgender Network: <http://community.pflag.org/transgender>

Gender Spectrum: www.genderspectrum.org

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children* (1 ed.). New York: The Experiment.

References

Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & dickey, I. m. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.

Edwards-Leeper, L., Leibowitz, S., Sangganjanavanich, V.F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.

Hidalgo et al., 2013. The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56, 285-290.

“During my senior year of high school, my English teacher would sit with me every day after school and listen as I told him how confused I was over my sexuality. He was one of the very few I told about being in conversion therapy. He told me that I had to listen to my heart and follow it, and not to try and force any specific outcome. He was the only person in my life at the time who gave me any assurance that I was going to make it through this.”

”

—Mathew

Summary and Conclusion

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition

and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

“It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life.”

—Sam

References

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Alanko, K., Santtila, P., Witting, K., Varjonen, M., Jern, P., Johansson, A., . . . Kenneth Sandnabba, N. (2009). Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. *J Sex Res*, *46*(5), 494-504.
- Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*, *38*(7), 1001-1014.
- American Bar Association. (2015). Resolution 112: Commission on sexual orientation and gender identify section of individual rights and responsibilities commission on youth at risk, from <https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf>
- American Medical Association. (2008). Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients, from http://www.tgender.net/taw/ama_resolutions.pdf
- American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5 ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013b). Principles of Medical Ethics, from <http://www.psychiatry.org/psychiatrists/practice/ethics>
- American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Washington, DC: American Psychological Association.
- American Psychological Association. (2008). Report of the APA task force on gender identity and gender variance (pp. 28). Washington, DC: American Psychological Association.
- American Psychological Association. (2009). Resolution on appropriate therapeutic response to sexual orientation distress and change efforts Retrieved August 26, 2015, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- American Psychological Association. (2010). Ethical Principles of Psychologists and Code of Conduct from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association (2011). Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients. Washington, DC: APA.
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *Am Psychol*, *67*(1), 10-42.
- American Psychological Association. (2015a). Guidelines for psychological practice with transgender and gender nonconforming people, from <http://www.apa.org/practice/guidelines/transgender.pdf>
- American Psychological Association. (2015b). Standards of accreditation for health service psychology. Washington, DC: American Psychological Association.

- American Psychological Association & National Association of School Psychologists. (2015c). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from <http://www.apa.org/about/policy/orientation-diversity.aspx>
- Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors. *American Psychologist*, *64*(5), 372-453. doi: 10.1037/a0015932
- APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on appropriate therapeutic responses to sexual orientation, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- APA Task Force on Gender Identity and Gender Variance. (2009). Report of the Task Force on gender identity and gender variance. Washington, DC: American Psychological Association.
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, *31*, 43-55.
- Bartoli, E., & Gillem, A. R. (2008). Continuing to depolarize the debate on sexual orientation and religious identity and the therapeutic process. *Professional Psychology: Research and Practice*, *39*, 202-209.
- Ben-Ari, A. (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality*, *30*, 89-112.
- Bethea, M. S., & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A Systems Theory perspective *Journal of Couple & Relationship Therapy*, *12*, 89-112. doi: 10.1080/15332691.2013.779094
- Bockting, W. O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality*, *17*(3/4), 125-134.
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, *103* (5), 943-951.
- Bontempo, D., & D'Augelli, A. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health*, *30*, 364-374.
- Bouris, A., Guilamo-Ramos, V., Pickard, A., Shiu, C., Loosier, P. S., Dittus, P., & Waldmiller, J. M. (2010). A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda. *The Journal of Primary Prevention*, *31*(5-6), 273-309.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard.
- Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.

- Burton, C. M., Marshal, M. P., Chisolm, D. J., Sucato, G. S., & Friedman, M. S. (2013). Sexual minority-related victimization as a mediator of mental health disparities in sexual minority youth: a longitudinal analysis. *J Youth Adolesc*, 42(3), 394-402.
- Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., . . . Tompkins, D. A. (2012). Report of the APA Task Force on treatment of gender identity disorder. *American Journal of Psychiatry, Suppl. 1-35*.
- Carver, P., Yunger, J., & Perry, D. (2003). Gender identity and adjustment in middle childhood. *Sex Roles*, 49(3-4), 95-109. doi: 10.1023/a:1024423012063
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4, 219-235.
- Cass, V. C. (1996). Sexual orientation identity formation: A western phenomenon. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 227-251). Washington, DC: American Psychiatric Press, Inc.
- Cochran, S. D., Drescher, J., Kismödi, E., Giami, A., García-Moreno, C., Atalla, E., Marais, E. M. V., & Reed, G. M. (2014). Proposed declassification of disease categories related to sexual orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). *Bulletin of the World Health Organization*, 92, 672-679. doi: 10.2471/BLT.14.135541
- Cohen-Kettenis, P. T. (2005). *Gender identity disorders*. Cambridge, MA: Cambridge University Press.
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. G. (2008). The treatment of adolescent transsexuals: Changing Insights. *Journal of Sexual Medicine*, 5(8), 1892-1897.
- Cohen-Kettenis, P. T., & Klink, D. (2015). Adolescents with gender dysphoria. *Best Pract Res Clin Endocrinol Metab*, 29(3), 485-495.
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.
- Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A., (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow up. *Archives of Sexual Behavior*, 40(4), 843-847.
- Cohen-Kettenis PT, Schagen SE, Steensma TD, de Vries AL, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011;40(4):843–847
- Cohen-Kettenis, P. T., & van Goozen, S. H. (1997). Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*, 36(2), 263-271.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.
- Corby, B. C., Hodges, E. V. E., & Perry, D. G. (2007). Gender identity and adjustment in Black, Hispanic, and White preadolescents. *Developmental Psychology*, 43(1), 261-266.
- Corliss, H. L., Rosario, M., Wypij, D., Wylie, S. A., Frazier, A. L., & Austin, S. B. (2010). Sexual orientation and drug use in a longitudinal cohort study of U.S. adolescents. *Addictive Behaviors*, 35(5), 517-521. doi: 10.1016/j.addbeh.2009.12.019
- Cotton, S., Zebracki, K., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: a review. *J Adolesc Health*, 38(4), 472-480.

- Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, 21, 1-21.
- D'Augelli, A. R., & Patterson, C. J. (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York: Oxford University Press.
- Daley, A., Solomon, S., Newman, P. A., & Mishna, F. (2008). Traversing the margins: Intersectionalities in the bullying of lesbian, gay, bisexual and transgender youth. *Journal of Gay & Lesbian Social Services*, 19(3-4), 9-29. doi: 10.1080/10538720802161474
- Delemarre-van de Waal, H.A. & Cohen-Kettenis, P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(suppl 1):S131–S137.
- de Vries, A., Steensma, T., Doreleijers, T., & Cohen-Kettenis, P. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*, 8(8), 2276–2283.
- de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry*, 52(11), 1195-1202.
- de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord*, 40(8), 930-936.
- Diamond, L. M. (2015). Sexual fluidity. *The International Encyclopedia of Human Sexuality*, 1115–1354.
- Diamond, L. M., & Butterworth, M. (2008). Questioning gender and sexual identity: Dynamic links over time. *Sex Roles*, 59(5-6), 365-376. doi: 10.1007/s11199-008-9425-3
- Diamond, L. M., & Savin-Williams, R. C. (2000). Explaining diversity in the development of same-sex sexuality among young women. *Journal of Social Issues*, 56, 297-313.
- Diamond, M. L. (2006). Careful what you ask for: Reconsidering feminist epistemology and autobiographical narrative in research on sexual identity development. *Signs: Journal of Women and Culture and Society*, 31, 471-492.
- Diamond, M. L. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, 44, 5-14.
- Doty, N. D., & Brian, L. B. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *Journal of Youth and Adolescence*, 39, 1134–1147.
- Doty, N. D., Willoughby, B. L., Lindahl, K. M., & Malik, N. M. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *J Youth Adolesc*, 39(10), 1134-1147.
- Drescher, J. (2014). Controversies in gender diagnoses. *LGBT Health*, 1(1), 10-14. doi: 10.1089/lgbt.2013.1500
- Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Dev Psychol*, 44(1), 34-45.
- Dube, E. M., & Savin-Williams, R. C. (1999). Sexual identity development among ethnic sexual-minority male youths. *Developmental Psychology*, 34, 1389-1398.

- Durso, L. E., & Gates, G. J. (2012). *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.
- Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & Dickey, L. M. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.
- Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary “Gender Management Service” (GeMS) in a major pediatric center. *Journal of Homosexuality*, 59(3), 321-336.
- Egan, S. K., & Perry, D. G. (2001). Gender identity: A multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology*, 37(4), 451-463.
- Elizur, Y., & Ziv, M. (2001). Family support and acceptance, gay male identity formation, and psychological adjustment: a path model. *Fam Process*, 40(2), 125-144.
- Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
- Fisher, C. (2015, August 31). Email – “Relevant APA Ethical Standards”.
- Floyd, F. J., & Bakeman, R. (2006). Coming-out across the life course: implications of age and historical context. *Arch Sex Behav*, 35(3), 287-296.
- Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health*, 101(8), 1481-1494.
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38(3), 230–236.
- Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: a meta-analysis. *Prev Sci*, 15(3), 350-363.
- Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43 573-589.
- Grossman, A., & D’Augelli, A. (2007). Transgender youth and life-threatening behaviors. *Suicide Life Threat Behav*, 37(5), 527–537.
- Grov, C., Bimbi, D. S., Nanin, J. E., & Parsons, J. T. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research*, 43, 115–121.
- Harari, E., Glenwick, D. S., & Cecero, J. J. (2014). The relationship between religiosity/spirituality and well-being in gay and heterosexual Orthodox Jews. *Mental Health, Religion and Culture*, 17(9), 886-897.
- Harper, G. W. (2007). Sex isn’t that simple: culture and context in HIV prevention interventions for gay and bisexual male adolescents *American Psychologist*, 62(8), 806.

- Harper, G. W., Jamil, O. B., & Wilson, B. D. M. (2007). Collaborative community-based research as activism: Giving voice and hope to lesbian, gay, and bisexual youth. *Journal of Lesbian and Gay Psychotherapy, 11*(3/4), 99-119.
- Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and Transgendered people and communities: a challenge for community psychology. *Am J Community Psychol, 31*(3-4), 243-252.
- Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels and otherwise in the National Transgender Discrimination Study *LGBT Policy Journal at the Harvard Kennedy School, 2*, 13-24.
- Hatzenbuehler, M. L. (2011). The Social Environment and Suicide Attempts in Lesbian, Gay, and Bisexual Youth. *Pediatrics, 127*(5), 896-903. doi: 10.1542/peds.2010-3020
- Hatzenbuehler, M. L., Pachankis, J. E., & Wolff, J. (2012). Religious climate and health risk behaviors in sexual minority youths: A population-based study. *American Journal of Public Health, 102*(4), 657-663. doi: 10.2105/ajph.2011.300517
- Hembree, W. C., Cohen-Kettenis, P., Waal, H. A. D.-v. d., Gooren, L. J., Walter J. Meyer, I., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132-3154. doi: doi:10.1210/jc.2009-0345
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice, 43*(5), 460-467. doi: <http://dx.doi.org/10.1037/a0029597>
- Herek, G. M. (2010). Sexual orientation differences as deficits: Science and stigma in the history of American psychology. *Perspectives on Psychological Science, 5*, 693-699.
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The Gender Affirmative Model: What we know and what we aim to learn. *Human Development, 56*, 285-290.
- Hidalgo, M. A., Kuhns, L. M., Kwon, S., Mustanski, B., & Garofalo, R. (2015). The impact of childhood gender expression on childhood sexual abuse and psychopathology among young men who have sex with men. *Child Abuse & Neglect, 46*, 103-112.
- Horowitz, J. L., & Newcomb, M. D. (2001). A multidimensional approach to homosexual identity. *J Homosex, 42*(2), 1-19.
- Hughes, I. A., Houk, C., Ahmed, S. F., & Lee, P. A. (2006). Consensus statement on management of intersex disorders. *Journal of pediatric urology, 2*(3), 148-162.
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academy of Sciences.
- Jarrett, V. (2015). Official White House response to enact Leelah's Law to ban all LGBTQ+ Conversion Therapy from <https://petitions.whitehouse.gov/response/response-your-petition-conversion-therapy>
- Kann, L., Olsen, E., McManus, T., Kinchen, S., Chyen, D., Harris, W., . . . Centers for Disease Control and Prevention (CDC). (2011). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12--youth risk behavior surveillance, selected sites, United States, 2001-2009. *MMWR Surveill Summ, 60*(7), 1-133.

- Knudson, G., De Cuypere, G., & Bockting, W. (2010). Recommendations for revision of the *DSM* diagnoses of Gender Identity Disorders: Consensus statement of the World Professional Association for Transgender Health. *International Journal of Transgenderism*, *12*(2), 115-118.
- Kohlberg, L. (1966). *A cognitive-developmental analysis of children's sex-role concepts and attitudes*. Stanford, CA: Stanford University.
- Kosciw, J. G., & Diaz, E. M. (2006). The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our schools. . New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kosciw, J. G., Greytak, E. A., & Diaz, E. M. (2009). Who, what, where, when, and why: Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence*, *38*(7), 976-988. doi: 10.1007/s10964-009-9412-1
- Kosciw, J. G., Greytak, E. A., Diaz, E. M., & Bartkiewicz, M. J. (2010). The 2009 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York, NY: GLSEN.
- Kosciw, J. G., Greytak, E. A., Palmer, N. A., & Boesen, M. J. (2014). The 2013 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research*, *49*, 244-254. doi: 10.1080/00224499.2011.596954
- Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology*, *52*(3), 378-388. doi: 10.1037/0022-0167.52.3.378
- Lee, P. A. (1980). Normal ages of pubertal events among American males and females. *Journal of Adolescent Health Care*, *1*(1), 26-29.
- Leibowitz, S., & Telingator, C. (2012). Assessing gender identity concerns in children and adolescents: evaluation, treatments, and outcomes. *Curr Psychiatry Rep*, *14*(2), 111-120.
- Leibowitz, S. F., & Spack, N. P. (2011). The development of a gender identity psychosocial clinic: Treatment issues, logistical considerations, interdisciplinary cooperation, and future initiatives. *Child Adolesc Psychiatric Clin N Am*, *20*, 701-724.
- Lev, A. (2005). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Clinical Practice Press.
- Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *Am J Prev Med*, *42*(3), 221-228.
- Majd, K., Marksamer, J., & Reyes, C. (2009). Hidden Injustice: Lesbian, gay, bisexual, and transgender youth in juvenile courts. New York: The Equity Project.
- Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., . . . Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, *49*(2), 115-123. doi: 10.1016/j.jadohealth.2011.02.005
- Maslowe, K.E. & Yarhouse, M.A. (2015). Christian parental reactions when a LGB child comes out. *The American Journal of Family Therapy*, *43*, 1-12.

- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. *Psychiatric Clinics of North America*.
- Meanley, S., Pingel, E. S., & Bauermeister, J. A. (2015). Psychological Well-being Among Religious and Spiritual-identified Young Gay and Bisexual Men. *Sexuality Research and Social Policy*. Advance online publication. 10.1007/s13178-015-0199-4
- Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender non-conforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1010-1013.
- Menvielle, E. J., Tuerk, C., & Perrin, E. C. (2005). To the beat of a different drummer: The gender variant child. *Contemporary Pediatrics*, 22, 38-39, 41, 43, 45-46.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), 674.
- Minter, S. (2012). Supporting transgender children: new legal, social, and medical approaches. *J Homosex*, 59(3), 422-433.
- Moon, D. (2014). Beyond the dichotomy: six religious views of homosexuality. *J Homosex*, 61(9), 1215-1241.
- Mustanski, B., Birkett, M., Greene, G. J., Hatzenbuehler, M. L., & Newcomb, M. E. (2013). Envisioning an America without sexual orientation inequities in adolescent health. *American Journal of Public Health*, 104(2), 218-225. doi: 10.2105/ajph.2013.301625
- Mustanski, B., Garafalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Am J Public Health*, 100(12), 2426-2432.
- Nakajima, G. A. (2003). The emergence of an international lesbian, gay, and bisexual psychiatric movement. *Journal of Gay & Lesbian Psychotherapy*, 7(1/2), 165-188.
- National Association of Social Workers. (2008). Code of Ethics of the National Association of Social Workers, from <http://www.naswdc.org/pubs/code/code.asp>
- Olson, K., Key, A., & Eaton, N. (2015). Gender cognition in transgender children. *Psychological Science*, 1-8.
- Ott, M. Q., Corliss, H. L., Wypij, D., Rosario, M., & Austin, S. B. (2010). Stability and change in self-reported sexual orientation identity in young people: Application of mobility metrics. *Archives of Sexual Behavior*, 40(3), 519-532. doi: 10.1007/s10508-010-9691-3
- Page, M. J. L., Lindahl, K. M., & Malik, N. M. (2013). The role of religion and stress in sexual Identity and mental health among lesbian, gay, and bisexual youth. *Journal of Research on Adolescence*, 23(4), 665-677. doi: 10.1111/jora.12025
- Parent, M. C., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles*, 68(11-12), 639-645. doi: 10.1007/s11199-013-0283-2
- Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Plenum.
- Ray, N., & National Gay and Lesbian Task Force. (2006). Lesbian, gay, bisexual, and transgender youth: An epidemic of homelessness. Washington, DC: National Gay and Lesbian Task Force Policy Institute.

- Ream, G. L., & Savin-Williams, R. C. (2005). Reconciling Christianity and positive non-heterosexual identity in adolescence, with implications for psychological well-being. *Journal of Gay & Lesbian Issues in Education, 2*(3), 19-36. doi: 10.1300/J367v02n03_03
- Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood gender nonconformity: A risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics, 129*, 410-417. doi: 10.1542/peds.2011-1804
- Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: An 11-year longitudinal study. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(2), 143-152. doi: 10.1016/j.jaac.2012.11.006
- Russell, S., Ryan, C., Toomey, R., Diaz, R., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health, 81*, 223-230.
- Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist, 46*(9), 1241-1257. doi: 10.1177/0002764202250667
- Russell, S. T., Toomey, R. B., Ryan, C., & Diaz, R. M. (2014). Being out at school: The implications for school victimization and young adult adjustment. *American Journal of Orthopsychiatry, 84*(6), 635-643. doi: 10.1037/ort0000037
- Ryan, C., & Diaz, R. (2005). *Family responses as a source of risk and resiliency for LGBT youth*. Paper presented at the Child Welfare League of America Preconference Institute, Washington, DC.
- Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. doi: 10.1542/peds.2007-3524
- Ryan, C., & Rees, R. A. (2012). Supportive families, healthy children: Helping Latter-day Saint families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Saewyc, E. M. (2007). Contested conclusions: Claims that can (and cannot) be made from the current research on gay, lesbian, and bisexual teen suicide attempts. *Journal of LGBT Health Research, 3*(1), 79-87.
- Saewyc, E. M. (2011). Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *Journal of Research on Adolescence, 21*, 256-272. doi: 10.1111/j.1532-7795.2010.00727
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology, 67*, 859-866.
- Salzburg, S. (2004). Learning that an adolescent child is gay or lesbian: The parent experience. *Social Work, 49*, 109-118.
- Salzburg, S. (2007). Narrative therapy pathways for reauthoring with parents of adolescents coming-out as lesbian, gay, and bisexual. *Contemporary Family Therapy, 29*, 57-69.

- Savin-Williams, R. (1994). Verbal and physical abuse as stressors in the lives of sexual minority youth: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62*, 261-269. doi: 10.1037/0022-006X.62.2.261
- Savin-Williams, R. C. (2001). *Mom, dad, I'm gay: How families negotiate coming out*. Washington, DC: American Psychological Press.
- Savin-Williams, R. C. (2005). *The New Gay Teenager*. Cambridge, MA.: Harvard University Press.
- Savin-Williams, R. C., & Ream, G. L. (2006). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior, 36*(3), 385-394. doi: 10.1007/s10508-006-9088-5
- Schlatter, E., & Southern Poverty Law Center. (2014, Dec. 13). North Carolina church members indicted for kidnapping and assaulting gay man, *Salon*. Retrieved from http://www.salon.com/2014/12/13/north_carolina_church_members_indicted_for_kidnapping_and_assaulting_gay_man_partner/
- Schope, R. D. (2002). The decision to tell: Factors influencing the disclosure of sexual orientation by gay men. *Journal of Gay and Lesbian Social Services, 14*(1), 1–22.
- Schope, R. D., & Eliason, M. J. (2000). Thinking versus acting: Assessing the relationship between heterosexual attitudes and behaviors towards homosexuals. *Journal of Gay & Lesbian Social Services, 11*, 69–92.
- Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301–311. doi: doi:10.1007/s11199-008-9501-8
- Siegel, M., & Robinson, J. (1987). Order effects in children's gender-constancy responses *Developmental Psychology, 23*, 283-286. doi: 10.1037/0012-1649.23.2.283
- Simons, L. K., Leibowitz, S. F., & Hidalgo, M. A. (2014). Understanding gender variance in children and adolescents. *Pediatr Ann, 43*(6), 00904481-20140522.
- Siraj, A. (2012). "I Don't Want to Taint the Name of Islam": The Influence of Religion on the Lives of Muslim Lesbians. *Journal of Lesbian Studies, 16*(4), 449-467.
- Smith, T. E., & Leaper, C. (2006). Self-perceived gender typicality and the peer context during adolescence. *Journal of Research on Adolescence, 16*, 91-104.
- Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry, 40*(4), 472-481.
- Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations, 64*(3), 420-430. doi: 10.1111/fare.12124
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. doi: 10.1542/peds.2011-0907
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry, 16*(4), 499-516.
- Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Arch Sex Behav, 40*(4), 649-650. doi: 10.1007/s10508-011-9752-2

- Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Horm Behav*, *64*(2), 288-297.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*, *52*(6), 582-590.
- Stewart, B. T., Heck, N. C., & Cochran, B. N. (2015). A comparison of sexual minority youth who attend religiously affiliated schools and their nonreligious-school-attending counterparts *Journal of LGBT Youth*, *12*(2), 170-188.
- Szalacha, L. A. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safe Schools Program for Gay and Lesbian Students. *American Journal of Education*, *110*, 58-88.
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, *46*(6), 1580-1589. doi: 10.1037/a0020705
- Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school Gay–Straight Alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science*, *15*(4), 175-185. doi: 10.1080/10888691.2011.607378
- Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papadimitriou, M. (2012). Impacts of strong parental support for trans youth: A report prepared for Children’s Aid Society New York: Children’s Aid Society.
- Troiden, R. R. (1988). Homosexual identity development. *Journal of Adolescent Health Care*, *9*, 105-113.
- Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality*, *17*(1), 43-73.
- Vance, S. R., Jr., Ehrensaft, D., & Rosenthal, S. M. (2014). Psychological and medical care of gender nonconforming youth. *Pediatrics*, *134*(6), 1184-1192.
- Vrangalova, Z., & Savin-Williams, R. C. (2012). Mostly heterosexual and mostly gay/lesbian: Evidence for new sexual orientation identities. *Archives of sexual behavior*, *41*(1), 85-101.
- Wallace, R., & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: toward a theoretical framework for evaluating clinical interventions. *Int J Transgenderism*, *14*(3), 113–126.
- Wallien, M. S. C., & Cohen-Kettenis, P. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(12), 1413-1423.
- Walls, N. E., Kane, S. B., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society*, *41*, 307–332. doi: DOI: 10.1177/0044118X09334957
- Wilbur, S., Ryan, C., & Marksamer, J. (2006). Serving LGBT youth in out-of-home care: Best practices guide. Washington, DC: Child Welfare League of America.
- Willoughby, B. L., Doty, N. D., & Malik, N. M. (2010). Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: the role of negative GLB identity. *Journal of GLBT Family Studies*, *6*, 403-424.
- World Health Organization. (1992). The International Classification of Disease 10th Revision (ICD 10). *Classification of mental and behavioural disorders—Clinical descriptions and diagnostic guidelines*. Geneva: WHO.

- World Professional Association for Transgender Health, I., . (2008). WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A., from http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947
- Yakushko, O. (2005). Influence of social support, existential well-being, and stress over sexual orientation on self esteem of gay, lesbian, and bisexual individuals. *International Journal for the Advancement of Counselling*, 27(1), 131-143.
- Yarhouse, M. A. (1998). When families present with concerns about an adolescent's experience of same-sex attraction. *The American Journal of Family Therapy*, 26, 321-330.
- Yarhouse, M. A. (2015a, July 7 and August 6). [Family approaches in therapeutic intervention].
- Yarhouse, M.A. (2015b, August. Family and Community Acceptance – focus on conventionally religious communities. Unpublished paper.
- Yarhouse, M.A. (2015c). Understanding gender dysphoria: Navigating transgender issues in a changing culture. Downer's Grove, IL: InterVarsity Press.
- Yarhouse, M. A., & Tan, E. S. N. (2005). Addressing religious conflicts in adolescents who experience sexual identity confusion. *Professional Psychology: Research and Practice*, 6, 530-536.
- Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Dev Psychol*, 40(4), 572-582.
- Zucker, K. (2004). Gender identity development and issues. *Child Adolesc Psychiatric Clin N Am*, 13, 551-568.
- Zucker, K. (2005). Gender identity disorder in children and adolescents. *Annu Rev Clin Psychol*, 1, 467-492.
- Zucker, K., & Bradley, S. (1995). Gender identity disorder and psychosexual problems in children and adolescents. New York: The Guilford Press.

Appendix A: Glossary of Terms

Cisgender: A person whose gender identity, gender expression, and sex assigned at birth all align.

Conversion therapy: Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

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

Gender expression: The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

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

Gender nonconforming, gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth which may or may not differ from their gender identity later in life.

Questioning: Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring one's sexual orientation and/or gender identity.

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

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

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

Transition: A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

Appendix B: Acknowledgments

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The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, Director LGBT Office) and Judith Glassgold, PsyD (Associate Executive Director, Government Relations, Public Interest Directorate).

The Expert Panel consisted of a panel of researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel included experts with a background in family therapy and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark A. Yarhouse, PsyD.

Endnotes

1. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, particularly common when youth are the population of focus.
7. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that “sexual orientation by itself is not to be considered a disorder.” Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD (Cochran, S. D., Drescher, J., Kismödi, Giami, García-Moreno, Atalla, . . . , & Reed, 2014).
10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one’s assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.

12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term “gender dysphoria” (lowercase) is used to broadly describe the discomfort or distress caused by the discrepancy between a person’s gender identity and that person’s sex assigned at birth and/or primary or secondary sex characteristics. We will use the term “individuals with gender dysphoria” throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.
13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.
16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources [Strengthening Protection against Discrimination](#).
20. For example, “A Practitioner’s Resource Guide: Helping Families to Support Their LGBT Children” <http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS>. Another helpful resources is “Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children” http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.
21. See for instance, American Psychological Association (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.
22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at <https://www.aamc.org/download/414172/data/lgbt.pdf>.
23. Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at <https://www.americanbar.org/content/dam/aba/images/abans/2015annualresolutions/112.pdf>.



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