

# Banning Therapy to Change Sexual Orientation or Gender Identity in Patients Under 18

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Five U.S. states, the District of Columbia, and one Canadian province have enacted laws forbidding the practice by mental health professionals of what is commonly termed “conversion therapy” or “reparative therapy.” In a person younger than 18, such therapy is meant to change sexual orientation, gender identity, or gender behaviors. I contend that these laws are problematic from both psychiatric and legal perspectives.

## Legislation

California law states:

... under no circumstances shall a mental health provider engage in sexual orientation change efforts with a patient under 18. Sexual orientation change efforts mean any practice that seeks to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.<sup>1</sup>

Illinois enacted the Youth Mental Health Protection Act “to protect transgender youth from sexual orientation change efforts, also known as conversion therapy . . . changing an individual’s sexual orientation (includes) efforts to change behaviors or gender expressions.”<sup>2</sup>

Oregon, in House Bill 2307, stated “A mental health care or social health professional may not practice conversion therapy (with a person) under 18 years . . . for the purpose of attempting to change a

person’s gender identity (or) attempting . . . to reduce sexual or romantic attraction toward individuals of the same gender.”<sup>3</sup>

New Jersey law (2013) states “a person who is licensed to provide counseling . . . shall not engage in sexual orientation change efforts with a person under 18 years of age. . . . ‘sexual orientation change efforts’ means the practice of seeking to change a person’s sexual persuasion, including efforts to change behaviors or gender expressions.”<sup>4</sup>

Washington, D.C., in 2015 passed the “Conversion Therapy for Minors Prohibition Amendment Act” that “prohibits seeking to change a minor’s . . . gender identity or gender expression” or to “reduce or eliminate sexual or romantic attractions . . . toward persons of the same sex.”<sup>5</sup>

New York legislation provides that “. . . conversion therapy is not a permissible form of treatment for minors in facilities under the jurisdiction of the Office of Mental Health . . . . No facility shall provide services to minor patients that are intended to change such minor’s sexual orientation or gender identity, including efforts to change behaviors, gender expressions . . . .”<sup>6</sup>

In 2015, Ontario, Canada, enacted An Act to amend the Health Insurance Act and the Regulated Health Professionals Act, 1991. It states, “no person shall provide any treatment that seeks to change sexual orientation or gender identity of a patient under 18 years . . .”<sup>7</sup>

Banned treatments do not include services that provide “identity exploration or development” (e.g., Canada, New York).

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## Controversy About Treatment

Predating contemporary controversies over treatment of sexual orientation and childhood gender dysphoria, treatment of homosexuality was generally accepted. For decades, it was a disorder in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM). Treatments included psychoanalysis, aversion therapy, and religious-based intervention. More recently, a variety of methods came to be grouped as "conversion therapy" or "reparative therapy."

Whereas homosexuality *per se* was dropped by the APA as a disorder in 1973,<sup>8</sup> in 1980, gender identity disorder was added, addressing cross-gender identification and behaviors of children and adults. Although homosexuality is no longer categorized as a disorder, gender identity disorder, or transsexualism, or gender dysphoria remains in the current DSM (Fifth Edition).<sup>9</sup> Therefore, the argument against attempting to modify sexual orientation because it is not a disorder is not symmetrical with attempts to modify or treat gender dysphoria.

I have worked with transsexual individuals since the mid-1960s and published a paper advocating delisting homosexuality as a disorder before its removal.<sup>10</sup> I have experienced the sea changes regarding both phenomena as breathtaking: from crime and mental disorder to same-sex marriage, from no U.S. medical center performing transsexual surgery to widespread practice and public acceptance.

In addition, my 13 years of clinical experience at the world's largest adult transsexual treatment facility, with two to three operations a week, have continued to teach that it is generally a considerably more difficult life journey for the person who is transsexual than for the person who is homosexual. Hormonal and surgical procedures are not without risk and are imperfect in their outcome and, for some, there is unwanted reproductive sterility.

## Sexual Orientation and Gender Identity

The interrelation of adult gender identity and sexual orientation, with one predicting the other, is poor. Most persons sexually attracted to same-sex persons have a gender identity consistent with their natal sex. About a third of natal males with substantial cross-sex identity who live as women are sexually attracted to females. About 1 in 10 natal females who live as men are sexually attracted to males.

Childhood gender identity and adult sexual orientation are better correlated. My 15-year follow-up study with children who were substantially cross-gendered,<sup>11</sup> as well as the experience of others,<sup>12</sup> demonstrate that most prepubertal children diagnosed with gender identity disorder matured as homosexual persons, not transgendered. However, there is no childhood diagnostic test for accurate prediction of adult psychosexual status.

There is no practical strategy for changing sexual orientation in an 8-year-old. At ages in which sexual orientation remains unverballyized it would be problematic to gain parental consent to enquire into the nascent sexual orientation. Therefore, the legislative target forbidding treatment of all persons less than 18 years of age is overbroad. Attempting to change sexual orientation or gender identity in a 17-year-old (unlikely and potentially harmful)<sup>13,14</sup> is not comparable with attempting to change identity or behaviors in a 5-year-old.

A comprehensive review by the American Psychiatric Association concluded that there is no evidence that the effects of changing gender behaviors in children affects later sexual orientation.<sup>15</sup> Thus, if the prime target of legislation is eliminating treatments viewed as prevention of homosexuality, it could provide a basis for a legal claim against the gender behavior aspect of the legislation.

## Therapist Freedom of Speech

A legal challenge to the prohibition of a mental health practitioner's attempting to modify gender expression could be that it abridges free speech, a fundamental legal right. Psychotherapy, as a "talking cure," becomes the basis of the challenge. To date, this argument has had mixed results.

The California law was challenged and upheld by a federal court.<sup>16</sup> The court found that the law prohibited treatments deemed harmful and that parents have no authority to choose a harmful treatment for their child. Further, therapists' arguments that the law infringed on their right to the constitutional protection of free speech were rejected because therapy was held to be conduct, not speech. It does not harness the highest level of constitutional scrutiny against interference via state control.

Another court, considering the New Jersey law, held psychotherapy to be speech, but it was not fully protected and could be regulated by the state.<sup>17</sup> The court held that, although the law regulates speech, it

is permissible, “to protect its citizens from harmful or ineffective professional services.”

### State Regulation of Mental Health Practice

The state’s authority to dictate a type of practice to mental health specialists could be another avenue of attack on the recent laws. However, there is precedent for states’ enacting controls.

Psychoanalysis by unlicensed practitioners was barred in California. The regulation was unsuccessfully challenged by a national association of psychoanalysts whose members did not meet the California standard.<sup>18</sup> Berkeley, California, passed an ordinance forbidding electroconvulsive therapy (ECT) within its jurisdiction in 1983. The law was declared unconstitutional because of a broader state law regulating ECT.<sup>19</sup>

Other potential actions of therapists come under state control. These include sexual contact, assault, and withholding needed medication. Further, whereas patient–clinician confidentiality is a cornerstone in psychotherapy, it is not limitless. When a patient reports actual or potential sexual contact with a minor<sup>20</sup> or poses a significant physical threat to an identified victim, reporting is mandatory.<sup>21</sup>

### Perceived Harm of Interventions

The overriding intent of the recently enacted legislation is prevention of harm. If a prohibition is adopted to protect a minor patient, it can be easily sustained. Regarding proof of harm, courts have held that the lowest tier of scrutiny be applied: a rational relationship to a legitimate state interest. Such review does not provide “a license for courts to judge the wisdom, fairness, or logic of legislative choices.”<sup>22</sup>

A benefit/risk analysis addresses these potentials in the short and long term. Short-term benefits of reduced cross-gender expression could include reduced distress over discontent with natal sex and reduced stigma from peers for cross-gender expression. Short-term risks could include distress over not being permitted to express the need for cross-gender behaviors and conflict with parents over the imposed limitations. Long-term benefits of childhood transition to the other gender could include more time developmentally to evaluate whether to live as a person of the nonnatal gender. An intermediate-term risk could be the potential problems associated with returning to living as a

person of the natal sex if the trial period of cross-gender living is not successful. A longer-term risk of childhood transition includes promoting a transsexual outcome that might have been diverted, with the disadvantages noted above. There is no professional consensus on these options.<sup>15</sup>

Two negative outcomes at long-term follow-up of men seen by therapists for extensive cross-gender behavior when they were 5 years old in the late 1960s are reported. One, now an academic professor, was seen in a department of psychiatry. He has written extensively on his experience and its implications.<sup>23</sup> When interviewed as a gay man at 20, he was asked whether, if he had a son behaving as he did at 5, he would expose him to a similar psychotherapy program. He answered in the affirmative. However, years later he recognized that the intervention had been “more harmful than helpful.” It made him “feel ashamed of some aspects of his personality.”<sup>24</sup>

The second had been engaged in a highly structured behavior modification program in a department of psychology and at home. Masculine behaviors were positively reinforced; feminine behaviors were punished. As a 38-year-old gay man, he committed suicide. The family ascribed responsibility to the early childhood treatment.<sup>25</sup>

Systematic follow-up of other adults seen before adolescence by therapists with the goal of compatibility with natal sex will help provide needed evidence, not speculation.

### Parental Authority

Parental rights could be harnessed in attempting to overturn the recent laws if parents want the therapy for their child. Vaccination laws, education, and blood transfusion provide examples of limitations and strengths of parental authority.

Antivaccination sentiment and refusal have implications for public health, not only for one’s family, but also for others. The “herd immunity” phenomenon states that, when a threshold number of persons in a community are not inoculated, there are risks of epidemic.

Religious practice is a fundamental right with the strictest scrutiny of constitutional protection. Most U.S. states exempt vaccinations on religious grounds.<sup>26</sup> This appears to trump the refusing family’s child’s vulnerability to harm where childhood illnesses carry a risk of complications as well as risk to the community.

In consideration of their religious doctrine, Amish parents were given wide berth regarding education of their children. The children were withdrawn from state schools at 13 years of age. Implications include later disadvantage in the larger society. The parental right was upheld by the Supreme Court.<sup>27</sup>

Parental insistence on intervention to modify a child's gender behaviors on the grounds that it would diminish prospects of a life style that is anathema to their religious beliefs could have some traction, unless the consequences of intervention were substantial. Clearly, the consequences would not rise to the level of a parental demand, based on a religious tenet of Jehovah's Witnesses, to withhold a potentially life-saving blood transfusion.<sup>28,29</sup> That is not allowed.

### Overbreadth

As a legal argument to overturn a law, overbreadth is generally operant in the highest level of scrutiny assessment of free speech. When a prohibition extends from a legitimate to an illegitimate target, the statute can be struck down as overstepping constitutional bounds. The legitimate part of the legislation may be maintained.

To date, courts have examined the constraints of recent legislation under a low level of scrutiny, the rational basis test. This standard is not toothless. Although there is a body of evidence that demonstrates harm from therapist efforts to change homosexual orientation in adolescents, evidence of harm with preadolescents is wanting in consequence of its problematic exploration, as noted above.

Attempts to change gender identity after early adolescence are generally unsuccessful. If the prohibition of therapists' attempting to modify gender identity leads to patient protection, there is limited evidence that intervention is harmful in prepubertal minors. There is less evidence that changing early gender behaviors affects later sexual orientation, a primary forbidden target for patient protection.

### Conclusion

The portions of the new legislation targeting gender identity and gender expression may fail the lowest level of review, that of not demonstrating a rational basis for its inclusion. However, the "identity exploration and development" permitted in the recent legislation has

not been tested and may be a gray area for exchange among therapists minors and parents. Even if not legally overbroad, the recent legislation with its conflation of sexual orientation and gender identity remains psychiatrically incoherent.

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## Green

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