An International Declaration on 'Conversion Therapy' and Therapeutic Choice

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International Federation for Therapeutic and Counselling Choice

Signatories of this International Declaration call upon our governments, local authorities, human rights, media institutions and religious organisations, to recognise that the right to self-determination is an established principle of international law, and therefore must include the right to shape and develop one's own sexual identity, feelings and associated behaviours, and to receive support to do so.

We acknowledge that this International Declaration primarily addresses western nations in the northern hemisphere. We recognise that around the world, some cultures and subcultures differ markedly from these social contexts - and they may have a different understanding of terminology such as 'conversion therapy' and therapy bans. We emphasise that we do not support aversive, coercive, or shaming treatments, however they are termed, and regardless of whoever applies them or wherever they are practised.

List of abbreviations:

SSA: same-sex attracted/same-sex attraction/s
SSB: same-sex behaviour
'GD': 'gender dysphoria'
'CT': 'conversion therapy'
OSA: opposite-sex attracted/opposite-sex attraction/s
OS: opposite-sex

1. Banning 'conversion therapy' infringes human rights and freedoms, imperilling both therapeutic choice and pastoral, professional and parental rights.

1. This document will review evidence showing that sexuality is fluid. Research indicates that some people successfully reduce or in some cases overcome, undesired same-sex attraction (SSA) or same-sex behaviour (SSB)[1,2,3,4,5,6]. Research on treating potential causal links between psychiatric conditions and 'gender dysphoria' ('GD') or incongruence is in its infancy. ('GD' is distress about one's sex, and gender incongruence is disidentifying with one's sex in whole or in part.) Case studies and small studies are the best available gender therapy evidence at this time and these do show that some people reduce or change 'GD' through therapy[7,8].

2. Everyone has the right to reduce or change unfulfilling or undesired sexual feelings or behaviours, regardless of their motivations, goals or values. The right to align one's feelings and behaviours to biological sex, in order to feel comfortable with one's body or to live according to the values and beliefs that bring them true happiness, is a human right. No one should take these freedoms and rights away from any individual. Individuals should be free to make their own choices – politicians, activists, and mental health practitioners should not dictate their actions.

3. We reject widespread media misrepresentation and disinformation which has uncritically adopted 'conversion therapy (CT)' nomenclature based on the false philosophical and ideological premise that sexual 'orientation' is innate and immutable.

4. We know of no mental health guilds, however radical, that say SSA is inborn and unchangeable. Also, we know of no mental health guilds that say incongruent gender identity is inborn[9,10,11]. The American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5, p. 451)[12], specifically says 'GD' is not caused by having the brain of the opposite sex or an intersex condition of the brain. It also says, "In contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development." A global consensus statement on disorders of sexual development, that include intersex conditions, by several endocrine societies around the world, says there is no consistent evidence that brain structures are different for gender incongruent people and gender congruent people. It says masculine or feminine aspects of the brain largely develop 'gradually' (after birth) in interaction with psychological, social, and cultural experiences in the person's environment[13].

5. Definitive research has established that the development of SSB or SSA is not genetically determined[14]. Instead, environmental and cultural factors have been found to exert the greatest influence. Same-sex sexual feelings and dysphoria over one's sex emerge out of formative life experiences. Many begin very early, like other complex human traits that professional therapists routinely help people diminish or change.

6. We therefore object to ongoing discrimination against persons preferring their heterosexual side and those formerly LGBT-identified, those with non-heterosexuality who do not identify as LGBT and any who have

sought, or will in the future seek professional counselling or pastoral help to assist their transition from undesired behaviours and feelings.

2. Professional bodies promoting discriminatory monocultural viewpoints prevent ideological diversity and critique.

7. We deplore the discrimination emerging in western mental health bodies by which dissenting views of sexuality and gender are disallowed on ideological rather than scientific grounds. This has led to monocultures of intolerance where research, leadership, funding, collegiality, supervision and guidance are provided from only one viewpoint. As a result, this built-in bias is confirmed. Unbiased enquiry research tests hypotheses; advocacy research promotes pre-determined, tendentious hypotheses. Those advancing alternative hypotheses (for example, when supporting change-allowing therapies for undesired SSA) are at risk of professional discrimination and marginalisation.

8. This monocultural viewpoint, means those supporting individuals with undesired SSA or gender incongruence are labelled as providing 'CT' and associated with 'homo-trans-phobic' hate-speech. In itself, this is bullying language. We will stand with this population in objecting to ongoing discrimination, coercion and bullying against them and those who support them.

3. 'Mostly-heterosexuals', the largest non-heterosexual minority group, are being denied therapeutic support to affirm their heterosexual aspirations.

9. The American Psychological Association's *APA Handbook of Sexuality and Psychology* says that among same-sex attracted people, "individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception"[15]. The same *Handbook* also accepts, "…research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviours, or identities"[16,17]. Study after study finds that – if offered a Likert Scale of response – most people say they are only attracted to the opposite sex or are heterosexual – but the next largest group is 'mostly attracted' to the opposite sex, or 'mostly heterosexual'[18,19,20,21,22,23,24,25]. What cannot be ignored, is that, next to heterosexuality, the largest identity group is 'mostly heterosexual'.

10. Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)[26,27] showed that most persons who have had same-sex partners have also had opposite-sex (OS) sex partners, and many report experiencing sexual attraction to both sexes. Less than half of these persons identify as gay, lesbian or bisexual and many resolve this disparity, over time, in favour of sexual relations with persons of the opposite sex. In particular, Natsal-3 showed approximately 2.9% were sexually active with the same sex or both – but another 2.9% had desisted same-sex sex five or more years ago (S2 Table[28]). Most of these desisters were sexually active with the opposite sex and identified as heterosexual. The size and significance of this demographic is ignored and increasingly discriminated against by society and policy makers.

11. This pattern of relationships with the opposite sex is corroborated by the UK's Office for National Statistics[29] which shows that almost a quarter of people identifying as bisexual marry – almost always with the opposite sex. Both-sex attracted people deserve support in their heterosexual relationships and goals and should not be inhibited from considering OS sex relations, just because they have also experienced SSA as well as opposite-sex attraction (OSA). The state should ensure that freedom by specifically declaring such support is not 'CT'. Helping professionals should be free to affirm the entire diversity of sexual possibilities open to the client, and not be afraid that doing so might be interpreted as 'CT' under penalty of law. This affects particularly bisexuals and 'mostly-heterosexual' people. Supporting non-heterosexual people who want opposite-sex marriage or are married to the opposite sex, is vital. Sweeping and ill-defined definitions of 'CT' will prevent such support.

4. Sexual fluidity happens in both directions but this is being ignored.

12. Across the world, robust studies have established that sexual fluidity can happen in both directions, that change to or towards heterosexual attraction is common, and this is not limited to the 'mostly-heterosexual'. The lack of acknowledgement of this pattern is partly due to politics, but is also due to proportion and number. Heterosexuals hugely outnumber other sexualities. So even a tiny proportion of heterosexuals moving to or towards homosexuality, can outnumber even a large proportion of sexual minorities moving to or towards heterosexuality. Policy has ignored the evidence for the latter demographic, and

as a result their freedoms are at risk. Governments have a duty to protect the rights of sexual minorities to choose OS relationships as well as same-sex relationships – and not to be pathologised in doing so[30,31,32,33]. Researchers, therapists, and clients should be able, in principle, to identify factors that are leading to these changes all around us and use this knowledge to help people who are desiring change.

13. In the USA's 2012 National Longitudinal Study of Adolescent Health, over a six-year study[34], nearly three-quarters of those equally attracted to both sexes experienced change in sexual attraction, mostly toward or to heterosexuality. More than a fourth of exclusively SSA women changed, about half of these to exclusively heterosexual attraction. One in twelve to thirteen of exclusively homosexually attracted men also changed, mostly to exclusively heterosexual attraction. Female 'mostly heterosexuals' outnumbered all other SSA categories for both sexes together. Over a third of mostly-heterosexual women changed to heterosexual, only one in 56 changed to homosexual. A change we see in therapy that has not been studied in research is that some who do not develop OSA do experience decrease or an end to SSA through therapy, making it easier for them to be abstinent as they desire.

14. As reviewed by Diamond and Rosky (2016)[35], the datasets of several other robust, international studies have evidence that corroborate these patterns of change in sexuality: Growing Up Today Study – 'GUTS' – (USA)[36]; National Survey of Midlife Development in the United States – aka 'MIDUS' or 'NSMD' – (USA)[37]; and Dunedin Multidisciplinary Health and Development Study -' DMHD' – (New Zealand)[38].

15. Diamond and Rosky (2016)[39] referred to the changes reported in the population studies as naturally occurring. In other words, life experiences shift or change sexual attractions. In addition, a recent longitudinal, clinical outcome study by Pela and Sutton (2021)[40], shows that therapy 'participants in this study reported significant fluidity or change toward heterosexual attraction expression and identity'.

16. From these studies, what is clearly evident, is that most people who identify as SSA, are both-sex attracted. Those who identify as both-sex attracted, indicate their relationships are mostly with the opposite sex and that for many of them, their sexual attraction shifts or changes, mostly toward or to heterosexual.

17. SSA is not a mirror image of OSA. For the respective populations involved, OSA is overwhelmingly fixed. SSA is overwhelmingly fluid and most often comes with opposite sex attraction too. Persons with both-sex attractions commonly experience fluidity in sexual attraction feelings and behaviour.

5. Banning 'conversion therapy' will extend 'cancel culture', silence dissent and inhibit free speech.

18. LGBT activists in governments and elsewhere conflate the ill-defined term 'CT' (including morally reprehensible and historically abandoned aversion techniques) with standard (predominantly psychodynamic, evidence-based) therapy conversations, explorations of fluid sexual attractions and pastoral conversations where individuals harmonise the wholeness of their religious and sexual selves. It is important to note that it was regulated medical professionals in some countries, for example the U.K., who in the past administered morally reprehensible aversion therapy, not today's counsellors and psychotherapists.

19. The term 'CT' was first used by the American psychologist and activist who opposed and continues to oppose, change-allowing therapy, Dr Douglas Haldeman in 1991[41]. Citing this ill-defined ideologically inspired phrase, legislative bans on so-called 'CT' impose restrictions, fines and criminal charges on any provider of standard psychotherapeutic and counselling approaches and pastoral care workers, who offer help to individuals voluntarily seeking support with undesired same-sex feelings and gender confusion.

20. The term 'CT' may function as hate-speech and is used to bully detractors. Moseley 2020[42] reports that the UN's Special Representative on Sexual Orientation and Gender Identity (SOGI), Madrigal-Borloz, attempted to apply this term (introduced 1991), retrospectively. Consequently, this led to an anachronistic reconstructing of the history of mental health – claiming that *"Most schools within psychology and psychiatry, bolstered by the mental disorder classifications of the 1940s to early 1970s, operated as providers of "conversion therapy"*[43]*.*

21. Advocates of so-called 'CT' bans use malicious language, such as 'harm' and 'torture' that misrepresents actual practices, in order to advance an ideological viewpoint. The same UN official, Madrigal-Borloz[44], characterises 'CT' as 'torture', with the intention of denigrating all help to move away from SSA and SSB, as inherently flawed. This conflation of the politicised notion of 'CT', torture and the harm narrative, is creating an atmosphere of taint-by-association, calculated to intimidate counsellors and therapists into aligning themselves with only LGBT-affirmative therapies and political advocacy. Disallowing any but these practitioners to offer professional space, irrespective of an individual's wishes, disregards personal rights of conscience, sexuality, gender and relationships, creating a one-way pathway for care, to only affirm LGBT living, ignoring well-documented evidence already referenced.

22. Inaccurately, one of the ways used to associate 'CT' and torture has been to conflate the terms 'electro-shock (ES)' and 'electro-convulsive shock (ECS)' therapies. This has resulted in an inflammatory, exaggerated characterisation of therapy used to explore sexual fluidity. Specifically, ECS therapy, as used and reserved for catatonia and severe depression, was never used to address SSB[45,46]. Neither ECS nor ES therapies are used by professionals working in this area in the 21st century. Coupling torture and therapy is both inaccurate and disingenuous when describing therapeutic interventions for undesired SSB now available.

23. The signatories to this Declaration recognise the generic idea of sexual attraction fluidity exploration in therapy (SAFE-T) as a collective term and not as a new or 'exotic' therapeutic approach. This Declaration therefore does not support any coercive protocol or modality that claims to "cure" undesired sexual 'orientations'. Rather it endorses a range of psychotherapeutic and counselling modalities which are open to exploring sexual fluidity and change in sexual attraction, as one alternative among a number of possible therapeutic goals or outcomes[47].

24. These bans harm those living with undesired SSA, SSB, experiences or gender incongruence who seek change, because professionals are denied the opportunity to support client choice. The end goal appears to be the ending of 'heteronormativity' and the traditional roles of the nuclear family as espoused by such groups in the UK for example, as the Gay Liberation Front (1970)[48] and Elly Barnes, the CEO of Educate and Celebrate[49]. The demise of the nuclear family has been highlighted recently by journalist and social commentator, Melanie Phillips[50].

25. The IFTCC will continue to challenge political attempts that deny individuals their right to self-determination, autonomy and choice in sexual expression and identity, congruent with more primary religious or philosophical beliefs or relationships or personal needs or desires. It will do so by continuing to facilitate self-regulation, professional development and collegiality in the practices of our supporters. Our work will continue to explore the scientific, ethical and professional literature along with evidence-based research and the best practice available to us.

6. Political aspirations sacrifice much needed therapy for children and adults who feel distress about their sex.

26. 'CT' bans for minors will effectively prohibit children with 'gender dysphoria' from being offered and receiving what the government of Finland, for example, has determined based on research, should be the first line treatment for 'GD'. This involves treating psychiatric conditions that may predispose adolescents to onset of 'GD', that is, psychological interventions to help them to be comfortable with their biological sex, and not medically interfering with their bodies until they mature to age 25[51,52,53]. Contrary to this, so called medical affirmative care, trying to change the body to match the feelings, is insufficiently evidenced with few studies on the long-term effects of gender affirming treatment in children[54]. However, there is a plethora of evidence highlighting harmful side effects of this approach, such as sterility, infertility, reduced bone-mass and voice changes, etc[55].

7. 'Conversion therapy' bans are unsafe while potential causal links between trauma and same-sex attractions and 'gender dysphoria' remain unexamined.

27. The American Psychological Association's *APA Handbook of Sexuality and Psychology* accepts that research indicates that trauma has potential causal links to having same-sex partners[56,57.] International research shows that psychiatric conditions (psychiatric

disorders, neurodevelopmental disabilities, suicidality, and self-harming behaviour) also have potential causal links to adolescent gender incongruence[58] or adolescent 'gender dysphoria' ('GD')[59]. Despite the fact that there is currently insufficient research to explain the causes of any unwanted SSB or 'GD', authoritative bodies have irresponsibly moved ahead with 'CT' bans. They are doing this despite knowing that there are potentially causal trauma links but without conducting the research needed to determine what role trauma plays in the formation of SSB and 'GD' therefore how to care adequately for those distressed by their SSB or 'GD'.

8. Change-allowing therapies do not actually cause 'harm' or increase suicidality according to peer-reviewed research.

28. Contrary to media reports, new peer-reviewed research has found that change-allowing therapy does not increase suicidality or harmful behaviour and appears to reduce suicidality, in some cases dramatically, even for people who remain LGB-identified, who do not experience the change they hoped for through therapy[60,61].

29. Recent research has found that "Concerns to restrict or ban SOCE [sexual orientation change efforts] due to elevated harm are unfounded"[62]. A nationally representative study of 1,518 LGB identified people in three cohorts over a half a century who reported they experienced 'CT' (religious in nature in 88% of the cases) was conducted using a data set that was collected by LGBT-change-opposing researchers at the Williams Institute at the University of California at Los Angeles[63.] The researchers (Blosnich et al., 2020), however, looked only at lifetime rates of suicidality and found these rates were higher for people who reported they ever had 'CT', thereby introducing bias. Although, the authors stated this association did not prove causation, they then proceeded to act as though it did, introducing further bias, and recommended banning therapy. Despite before and after therapy suicidality rates in this data set being available, they did not use them. Sullins (2021) analysed the same data set using all the data available, namely before and after therapy, not just after therapy. He found most of the suicidality existed before therapy, not after. Unsurprisingly, people who were suicidal went to counselling more often than people who were not suicidal, and the counselling reduced their suicidality. Since the study was nationally representative, the generalisation can rightfully be made, that SOCEs reduce suicidality in LGB-identified people who do not change (they continue to identify as LGB)[64,65]. The same data set revealed that there were no differences between LGB people who experience SOCE and those who did not experience SOCE on measures of psychological distress, current mental health, substance abuse, alcohol dependence, and self-harming behaviours[66].

30. Media reports of harm are often sourced from hostile activists' undercover investigations[67,68,69,70].

31. Self-reporting to biased journalists, who are unwilling to corroborate the claims or offer alternative accounts, is common practice, resulting in widespread disinformation on this topic. We support investigations of alleged therapeutic malpractice where cases have been reported with at least *prima facie* evidence to support the defence. We do not support biased self-reporting.

9. Torture claims in 'conversion therapy' by are unsubstantiated and are designed to silence decent.

32. Portraying 'CT' as torture was alleged by the apparently inconsistent testimonial intervention of Samuel Brinton, sponsored by the National Center for Lesbian Rights (NCLR), an organisation that originated and continues to promote the therapy ban campaign. This was presented at the United Nation's 53rd Committee Against Torture session, in Geneva, in 2014[71]. Brinton's testimony failed to name his alleged therapist abuser, has contradicted details of his testimony in other settings, and has been judged untruthful by competent forensic analysis. He even later denied and rejected this account he initially made[72].

33. UN independent experts' reports are not authoritative. The 2020 independent SOGI (Sexual Orientation and Gender Identity) expert, Madrigal-Borloz, submitted an anti-change-allowing therapy report to the Human Rights Council (HRC) called, "*Practices of So-Called 'Conversion Therapy'; Report of the Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity"*. This report does not represent a position of the United Nations. There are 192 UN Member States and they have not as a whole adopted or accepted his report as policy. (Example, OIC, 2016; OIC[73,74].) Yet the International Rehabilitation Council for Torture Victims (IRCT), of which he was the Secretary General

until June 2019, published a statement in 2020, "*It's Torture not Therapy: a Global Overview of Conversion Therapy: Practices, Perpetrators, and the Role of States*"[75]. In section 62, the report claims "*The United Nations anti-torture machinery has concluded that they can amount to torture, cruel, inhuman or degrading treatment*". However, we know of no UN binding treaty that even mentions therapy regarding sexual orientation or gender identity.

34. Despite claims of torture, there are no court cases where a licensed professional has been found to have administered torture or abusive treatment when addressing unwanted SSA. Rosik[76] delineates recommendations for the conduct of research, legislative and judicial deliberation which, to date, have not been applied in the debate about therapy bans.

35. Linking therapy bans and torture to licensed professional work appears to be aimed at ensuring such bans cannot be contested under any circumstances. We call on those reporting alleged abuse, to provide robust analysis of the evidence-base linked to the torture which they cite.

36. Valid therapeutic interventions are, by definition, client-driven, non-aversive and evidence-based. It is malicious and ideologically motivated to mischaracterise abuse claims as normative. Standard claims of torture are without substantiation. These are employed as convenient and emotionally loaded defamation, potentially jeopardising freedoms.

10. Church leaders conceding to unsafe 'conversion therapy' bans defame and undermine the potentially complementary roles of pastoral and professional counselling.

37. We warn the religious communities in our countries that proposed and enforced banning of therapeutic choice and aligned diplomatic initiatives or incentives, may well have the result of curtailing the freedom of parents to raise their children according to values consistent with their faith. It will be progressively used to curtail freedom of religion to practise and promote truth in the public space. It will revive a secular humanist order encouraging sexual licence, practised by the ancients across the gender boundaries and known as "pansexuality". This new religious framework is sometimes referred to as "pansexual humanism".

38. We affirm the Christian scriptures that distinguish between temptations and actions. There is a need for the Christian community to clarify terms such as 'celibacy', 'abstinence', and 'chastity'.

39. Concentrating only on pastoral rights and not the rights of people outside of the church, will lead to a void of help for those not having a Christian faith. Theologically, professional help that is scientifically informed, might be considered part of general revelation to mankind. We acknowledge the danger of making 'change' an idol or of insisting anything less than categorical change is an indication of a lack of faith. Many from no-faith and other-faith worldviews seek to leave LGBT attractions, behaviours and identities. Preserving Christian freedoms should not be at the expense of the rights of those seeking access to professional support outside of the church. Whilst such therapeutic support is neither necessary nor sufficient for a believer, such input may contribute to the spiritual development and wellbeing of those with faith. Professional therapy, and hence religious freedom in professional therapy, may not be part of Christian beliefs for every Christian, but it is for some. If the religious freedom of some people can be taken away, which freedom will be removed next?

Information about the IFTCC.

40. The IFTCC is a registered entity in Great Britain and serves an international community which supports our Mission, Value Statement, Practice Guidelines and this International Declaration on Conversion Therapy and Therapeutic Choice.

Professional Development.

41. The IFTCC will strive to offer an alternative association point for any professional, lay person, or organisation, ostracised by regulating bodies, or whose practice is hindered or disallowed by unsubstantiated, ideological pressure, that many of our governments have allowed or promoted resulting from the politicisation of sexuality. Professionals wanting to join like-minded organisations, such as the IFTCC, include therapists who have a positive desire to work with clients, their families, and their communities affected by issues highlighted in this document.

42. We will also continue to develop Practice Guidelines and the ethical framework that

underpins the work of any practitioner wishing to associate with us. We do not support aversive, coercive, or shaming treatment, and we do support education and training for parents, pastors, churches, and professional therapists. It is necessary to preserve freedom of speech and scientific inquiry for us to accomplish such education and training to all in any community. Seeking to do good to all, we are committed to promoting attitudes of respect, harmony and dignity towards those persons, currently or previously, identified as LGBT, those identifying as non-heterosexual who do not identify as LGBT - hidden, outed, condemned, punished or otherwise - and their families and communities.

43. We will continue to develop a training curriculum that provides learners with information about the research and scientific data supporting change-allowing therapies.

44. We will endeavour to make our practice guidelines, ethical standards and association criteria open to public and professional scrutiny.

45. In addition, we will continue to platform relevant, accurate research, especially that which has been ignored, is misrepresented or disfavoured. We will highlight research that is inaccurate, under scientific scrutiny, such as wrongly affirming the harm narrative and suicidality, where re-analysis of misused data has challenged outcomes[77,78].

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