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“Made to Feel Broken”: Ending Conversion Practices and Saving Transgender Lives

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“MADE TO FEEL BROKEN”: ENDING CONVERSION PRACTICES AND SAVING TRANSGENDER LIVES

BANNING TRANSGENDER CONVERSION PRACTICES: A LEGAL AND POLICY ANALYSIS. By Florence Ashley. Vancouver, B.C.: University of British Columbia Press. 2022. Pp. xiii, 249. \$32.95.

Reviewed by Jennifer Levi & Kevin Barry***

INTRODUCTION

The past year has witnessed an unprecedented, coordinated campaign by state governments to deny gender-transition care to transgender youth. On April 6, 2021, Arkansas became the first state in the country to ban such care.¹ On February 18, 2022, Texas Attorney General Ken Paxton issued a nonbinding opinion that mischaracterized gender-transition care for transgender youth as “child abuse,” and Governor Greg Abbott subsequently ordered the Department of Family and Protective Services to initiate investigations into the parents of transgender youth.² On March 30, 2022, Governor Doug Ducey of

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¹ Devan Cole, *Arkansas Becomes First State to Outlaw Gender-Affirming Treatment for Trans Youth*, CNN (Apr. 6, 2021, 6:56 PM), <https://www.cnn.com/2021/04/06/politics/arkansas-transgender-health-care-veto-override> [<https://perma.cc/82YM-2Q8E>]; Press Release, ACLU, *ACLU Sues Arkansas over Ban on Health Care for Transgender Youth* (May 25, 2021), <https://www.aclu.org/press-releases/aclu-sues-arkansas-over-ban-health-care-transgender-youth> [<https://perma.cc/C3FD-SSMC>]; see also *Healthcare Laws and Policies: Medical Care Bans*, MOVEMENT ADVANCEMENT PROJECT (Oct. 25, 2022), https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/youth_medical_care_bans [<https://perma.cc/B856-E54D>]. On May 18, 2021, Tennessee prohibited medical providers from providing hormone therapy to “prepubertal minors” (who are not even eligible for hormone therapy, reflecting the state’s lack of knowledge about this area of medical care). Orion Rummel, *Tennessee Becomes Second State to Pass Bill Limiting Medical Care for Trans Minors*, AXIOS (May 18, 2021), <https://www.axios.com/2021/05/19/tennessee-trans-minors-health-care> [<https://perma.cc/FF8D-VZB5>]; see WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 18 (7th ed. 2012) [hereinafter WPATH STANDARDS], https://www.wpath.org/media/cms/Documents/SOC%20V7/SOC%20V7_English.pdf [<https://perma.cc/2CQS-7SY6>]; see also Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims* 3 (Apr. 28, 2022) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374 [<https://perma.cc/L6U2-6TA7>] (stating that Texas Attorney General’s opinion letter regarding gender-transition care “falsely implies that puberty blockers and hormones are administered to prepubertal children, when, in fact, the standard medical protocols recommend drug treatments only for adolescents (and not prepubertal children)”).

² Letter from Greg Abbott, Governor of Texas, to Jaime Masters, Comm’r, Texas Dep’t of Fam. & Protective Servs. (Feb. 22, 2022), <https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf> [<https://perma.cc/X6KP-84LJ>] (stating that “Texas law . . . imposes a duty on [the Texas Department of Family and Protective Services] to investigate the parents of a child who is subjected to” gender-transition care); Boulware et al., *supra* note 1 (manuscript at 1).

Arizona signed legislation banning gender-transition surgery for minors.³ On April 8, 2022, Governor Kay Ivey of Alabama signed legislation criminalizing transitioning medications for transgender youth.⁴ And on June 2, 2022, Governor Ron DeSantis of Florida requested that the state board regulating physicians ban gender-transition care for transgender youth.⁵

Since 2021, legislatures in at least twenty-two states have introduced bills to ban medical care for transgender youth, with thirteen states seeking to criminalize such care⁶ and at least one state seeking to classify such care as child abuse as the Governor of Texas did.⁷ In addition to these flagrant efforts to deprive transgender youth of health care, numerous states have denied gender-transition health care to less visible constituencies, including denying gender-transition health care coverage to state and county employees,⁸ recipients of Medicaid,⁹ and people incarcerated in state correctional facilities.¹⁰

The recent wave of denials of gender-transition care to youth is rooted in the century-old pseudoscience of conversion practices, which seek to change a person's gender identity or sexual orientation.¹¹ These practices, which are at the heart of Florence Ashley's book, *Banning Transgender Conversion Practices: A Legal and Policy Analysis*, are among the oldest and most extreme forms of denying appropriate

³ Devan Cole, *Arizona Governor Signs Bill Outlawing Gender-Affirming Care for Transgender Youth and Approves Anti-trans Sports Ban*, CNN (Mar. 30, 2022, 5:35 PM), <https://www.cnn.com/2022/03/30/politics/arizona-transgender-health-care-ban-sports-ban> [<https://perma.cc/YFT9-FK86>].

⁴ Rick Rojas, *Alabama Governor Signs Ban on Transition Care for Transgender Youth*, N.Y. TIMES (Apr. 8, 2022), <https://www.nytimes.com/2022/04/08/us/alabama-transgender-law-ivey.html> [<https://perma.cc/Y7G3-B79J>].

⁵ Marc Caputo, *DeSantis Moves to Ban Transition Care for Transgender Youths, Medicaid Recipients*, NBC NEWS (June 2, 2022, 8:55 PM), <https://www.nbcnews.com/politics/news/desantis-moves-ban-transition-care-transgender-youth-medicaid-recipien-rcna31736> [<https://perma.cc/XTQ2-6JZY>]; see also Arek Sarkissian, *Florida Medical Board Moves to Block Gender Affirming Treatments for Minors*, POLITICO (Aug. 5, 2022, 7:00 PM), <https://www.politico.com/news/2022/08/05/florida-gender-affirming-medical-treatment-ban-00050174> [<https://perma.cc/CR56-R6H9>] (discussing Florida medical board's decision to begin the process of banning gender-transition care for youths).

⁶ *LGBTQ Policy Spotlight: Efforts to Ban Health Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT (Apr. 2021), <https://www.lgbtmap.org/2021-spotlight-health-care-bans> [<https://perma.cc/Q84J-7U6R>].

⁷ KERITH J. CONRON ET AL., WILLIAMS INST., PROHIBITING GENDER-AFFIRMING MEDICAL CARE FOR YOUTH 3 (2022), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2022.pdf> [<https://perma.cc/9XMV-4MF5>].

⁸ *Healthcare Laws and Policies: Medical Care Bans*, *supra* note 1.

⁹ *Id.*

¹⁰ See Jennifer Levi & Kevin M. Barry, *Transgender Rights & the Eighth Amendment*, 95 S. CAL. L. REV. 109, 130-47 (2021).

¹¹ See CHRISTY MALLORY ET AL., WILLIAMS INST., CONVERSION THERAPY AND LGBT YOUTH: UPDATE 2 (2019), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf> [<https://perma.cc/3CLX-RB8R>].

medical care to transgender people (pp. 10–11).¹² Like state laws banning gender-transition care for youth, conversion practices are predicated on the belief that being transgender and seeking supportive medical care is abnormal (pp. 10–11).¹³ And like the medical-care bans, conversion practices brutalize transgender youth — the former, by leaving youth with no way to resolve the conflict between their gender identity and their assigned sex, and the latter, by imposing harmful and scientifically invalid techniques in place of medically necessary, evidence-based care.¹⁴ The well-established medical consensus is that gender-transition care is medically necessary and safe and that conversion practices are ineffective and harmful, creating psychological distress and prompting suicide.¹⁵ Not surprisingly, some of the purported medical experts that states rely on to defend youth medical bans also support conversion practices.¹⁶

Conversion practices encompass a range of techniques, including behavioral therapy, play psychotherapy, and parental counseling (p. 26),¹⁷ and they are performed “by some licensed professionals in the context of providing health care and by some clergy or other spiritual advisors

¹² Boulware et al., *supra* note 1 (manuscript at 12 n.37); see MALLORY ET AL., *supra* note 11, at 2 (referencing the roots of conversion practices dating back to the late nineteenth century); Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT’L J. TRANSGENDER HEALTH S1, S20 (2022) [hereinafter *WPATH Standards Version 8*]. Conversion practices often go by other names, such as “conversion therapy” or “reparative therapy” (pp. 30–31). Because “therapy” connotes the safe and effective treatment of an illness or injury, it does not accurately describe conversion practices, which, for the reasons discussed below, are harmful and ineffective, and target healthy identities. See *infra* pp. 1125–32.

¹³ See also MALLORY ET AL., *supra* note 11, at 1.

¹⁴ See *WPATH Standards Version 8, supra* note 12, at S20 (“Gender identity change efforts . . . cause harm to [transgender and gender-diverse] people, and (like efforts targeting sexual orientation) are considered unethical. These efforts may be viewed as a form of violence.” (citations omitted)); Boulware et al., *supra* note 1 (manuscript at 12) (discussing well-documented “harm of not providing gender-affirming care”).

¹⁵ See Boulware et al., *supra* note 1 (manuscript at 12–15).

¹⁶ See MEREDITH MCNAMARA ET AL., A CRITICAL REVIEW OF THE JUNE 2022 FLORIDA MEDICAID REPORT ON THE MEDICAL TREATMENT OF GENDER DYSPHORIA 6–9 (2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20ofinal%20July%208%202022%20accessible_443048_284_55174_v3.pdf [<https://perma.cc/US4U-J2TS>] (stating that purported experts who oppose transition care have undisclosed conflicts of interest and demonstrated ideological biases, including “support[ing] mental health providers practicing conversion therapy,” *id.* at 7).

¹⁷ Historically, conversion practitioners attempted to treat LGBTQ people through other means, such as forced institutionalization, forced medication, castration, and the use of aversive conditioning, such as the inducement of nausea, vomiting, paralysis, and other punishments. See AM. BAR ASS’N, COMM’N ON SEXUAL ORIENTATION & GENDER IDENTITY, SECTION OF INDIVIDUAL RTS. & RESPS. & COMM’N ON YOUTH AT RISK, REPORT TO THE HOUSE OF DELEGATES 1 (2015) [hereinafter ABA RESOLUTION], https://www.americanbar.org/content/dam/aba/administrative/sexual_orientation/2015-hod-ann-mtg-doc-112.pdf [<https://perma.cc/MBT4-7W38>]; NAT’L CTR. FOR LESBIAN RTS. & HUM. RTS. CAMPAIGN, JUST AS THEY ARE: PROTECTING OUR CHILDREN FROM THE HARMS OF CONVERSION THERAPY 7 (2017) [hereinafter NCLR & HRC REPORT], <https://www.nclrights.org/wp-content/uploads/2017/09/just-as-they-are-sept2017-1.pdf> [<https://perma.cc/899V-YYFP>].

in the context of religious practice.”¹⁸ An estimated 698,000 LGBTQ adults in the United States have undergone conversion practices either from a licensed professional or a religious advisor or both at some point in their lives, with approximately half (350,000) having undergone such practices as youths.¹⁹ These practices, moreover, are not a relic of a bygone era: it is estimated that nearly 75,000 current LGBTQ youth will undergo conversion practices before they reach the age of eighteen.²⁰ A disproportionate number of these youths, moreover, are likely to be transgender. As Ashley notes, conversion practices appear to be more common among transgender people than nontransgender queer people, with between 13.5% and 18% of transgender people in the United States reporting being subjected to such practices (p. 13).²¹

While much of the literature on conversion practices has focused on sexual orientation, that is, “sexual orientation change efforts,” Ashley helpfully focuses attention on transgender conversion practices (p. 175).²² Although one may wish to dismiss these practices “as an antiquated, dying approach in a world that is rapidly growing more accepting of trans people,” Ashley warns that support for these practices has experienced a resurgence in recent years, with “[a]nti-trans voices alleg[ing] that society is in the midst of an unprecedented epidemic of youth falsely believing themselves to be transgender due to ‘social contagion’ and unexamined mental illness and trauma” (pp. 14–15).²³ Transgender conversion practices, they explain, are alive and well, and such practices continue to threaten the well-being of the transgender community (p. 16).

In recent decades, the transgender civil rights movement has sought to eliminate conversion practices to great effect. Twenty states and the District of Columbia have enacted legislation banning conversion practices for minors, with another six states and Puerto Rico partially

¹⁸ MALLORY ET AL., *supra* note 11, at 1; *see also* NCLR & HRC REPORT, *supra* note 17, at 8 (stating that conversion practices are “often found outside the therapist’s office . . . in pastoral counseling, in religious youth camps, in addiction treatment facilities, and in prayer and support groups”).

¹⁹ MALLORY ET AL., *supra* note 11, at 1.

²⁰ *See id.* Other estimates are much higher. *See, e.g.*, Anna Forsythe et al., *Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States*, 176 JAMA PEDIATRICS 493, 497 (2022) (estimating that, in 2021, 508,892 LGBTQ youth in the United States were at risk of being subjected to conversion therapy).

²¹ Ashley cites Canadian studies finding that 11–19% of trans people experienced conversion practices (p. 14). *See also* MALLORY ET AL., *supra* note 11, at 6 n.5 (noting that 6.7% of “LGB adults ages 18 to 59 . . . report having received treatment to change their sexual orientation,” compared with 13% of transgender adults who “report[ed] that one or more professionals tried to make them identify only with their sex assigned at birth or tr[ie]d to stop them from being transgender”).

²² Ashley states: “Academic scholarship, especially in law, has tended to focus on sexual orientation to the exclusion of gender. There is a dire need for more scholarship and especially legal scholarship on the matter” (p. 175).

²³ *See also* MCNAMARA ET AL., *supra* note 16, at 23–25 (discussing “discredited claims that ‘social contagion’ is leading teens to become transgender,” *id.* at 23).

banning such practices.²⁴ National public opinion polls show majority support for ending the use of conversion therapy on youth; for example, a 2019 poll found that over 50% of U.S. adults across all age groups and regions, including rural, suburban, and urban areas, support a ban on youth conversion practices by mental health practitioners, and only 18% oppose such a ban.²⁵ Public opinion among the states reflects a similar trend, with recent polls in Arizona, Florida, and Pennsylvania — three states without statewide bans — finding majority support for such bans.²⁶ The national and international medical community, including every major medical and mental health organization, has rejected conversion practices, as have the U.S. Substance Abuse and Mental Health Services Administration and numerous human rights organizations and faith groups.²⁷ Two federal courts of appeals have upheld bans in the face of constitutional challenges, and prominent providers of conversion practices have closed their doors.²⁸

Because a majority of people in the United States do not believe they know a transgender person,²⁹ disagreements as to the pace and breadth of transgender rights may be inevitable. Access to healthcare, however, should be a given — something everyone ought to be able to agree on. As with any law, bans prohibiting conversion practices can only do so much: politics limits their passage, and narrow drafting limits their potency (pp. 108–18). But they are lifesaving for many transgender people (p. 12) and an important predicate to the recognition of the dignity of all transgender people (p. 105).³⁰ At a time when there exists, in Ashley’s words, “a larger social project of oppressing and discrediting trans communities” (p. 13), bans on conversion practices do exactly the opposite. They are part of the project of securing transgender health and respect.

Florence Ashley’s book is a thoughtful, thoroughly researched, and important contribution to this project. Ashley powerfully articulates why conversion practices should be banned, what those bans should look like, and why they should withstand legal challenge.³¹ They also suggest additional work that remains, beyond the law, to eliminate

²⁴ *Conversion “Therapy” Laws*, MOVEMENT ADVANCEMENT PROJECT (Oct. 25, 2022), https://www.lgbtmap.org/equality-maps/conversion_therapy [<https://perma.cc/M5F6-XL8Z>].

²⁵ MALLORY ET AL., *supra* note 11, at 2.

²⁶ *Id.* at 3.

²⁷ See *infra* pp. 1130–32, 1135.

²⁸ See *infra* pp. 1133–34.

²⁹ Rachel Minkin & Anna Brown, *Rising Shares of U.S. Adults Know Someone Who Is Transgender or Goes by Gender-Neutral Pronouns*, PEW RSCH. CTR. (July 27, 2021), <https://www.pewresearch.org/fact-tank/2021/07/27/rising-shares-of-u-s-adults-know-someone-who-is-transgender-or-goes-by-gender-neutral-pronouns> [<https://perma.cc/63DQ-UX97>] (“[A]bout four-in-ten Americans (42%) say they personally know someone who is transgender . . .”).

³⁰ For more on the harm of conversion practices, see *infra* Part II, 1124–35.

³¹ Ashley discusses the harms of conversion practices (pp. 3–32), a model law for prohibiting conversion practices (pp. 130–73), and constitutional arguments supporting such laws (pp. 71–102).

conversion practices (pp. 108–29).³² In this Review, we expand on several key arguments advanced by Ashley — highlighting our agreement, discussing some limitations, and developing several areas that they gesture toward. Part I of this Review introduces the twin concepts of transgender identity and gender dysphoria. Part II discusses the overwhelming medical consensus supporting gender-transition care and the harmfulness of conversion practices. Part III discusses the constitutionality of bans on conversion practices, and Part IV discusses the model law that Ashley proposes and its relationship to the broader social movement to eradicate conversion practices, with particular attention paid to the undertheorized “troubled teen industry.”

I. TRANSGENDER PEOPLE AND THE DIAGNOSIS AND TREATMENT OF GENDER DYSPHORIA

To understand how conversion practices harm transgender people, it is first necessary to understand what it means to be “transgender,” what it means to be diagnosed with “gender dysphoria,” and, critically, the relationship between the two.

A. *Identity v. Diagnosis*

As the U.S. Supreme Court has stated, a transgender person is someone “who was identified as [one sex] at birth but who now identifies as a [different sex].”³³ Typically, people designated male at birth grow up to identify as male, and those designated female grow up to identify as female. For a transgender person, however, one’s body and identity as male or female, a concept known as gender identity, do not match.³⁴ There is now a scientific consensus that biological factors — most notably sexual differentiation in the brain — have a role in gender identity development and that a person’s gender identity is hardwired and impervious to change.³⁵

³² Ashley discusses the limitations of legislative bans on conversion practices (pp. 103–18) and the development of a professional culture that rejects such practices (pp. 119–29).

³³ *Bostock v. Clayton County*, 140 S. Ct. 1731, 1741 (2020).

³⁴ See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter DSM-5].

³⁵ See, e.g., Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973*, in GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16-1, 16-77 (Christine Michelle Duffy ed., 2014) (discussing recent medical studies pointing to biological etiology for transgender identity); Randi Kaufman, *Introduction to Transgender Identity and Health*, in THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337–38 (Harvey J. Makadon et al. eds., 1st ed. 2008) (“The predominating biological theory suggests that a neuro-hormonal disturbance takes place in the brain during embryological development. While the genitalia of the human embryo become differentiated as male or female during the 12th week of fetal development, the gender identity portion of the brain differentiates around the 16th week. If there

The number of transgender people relative to the general population is small. According to recent estimates, there are approximately 1.3 million transgender adults (0.5% of the adult population) and approximately 300,000 transgender youth aged 13 to 17 (1.4% of the 13–17 population) living in the United States.³⁶ Many individuals begin to understand their gender identity during prepubertal childhood and adolescence.³⁷

Gender dysphoria is the medical diagnosis used to describe the clinically significant distress that arises from the conflict between a transgender person's assigned birth sex and gender identity when they are not able to live consistent with their gender identity.³⁸ If left medically untreated, gender dysphoria can result in debilitating depression, anxiety, and, for some people, suicidality and death.³⁹ Accordingly, for well over four decades, federal courts have consistently recognized gender dysphoria (and its precursors) as a serious medical condition.⁴⁰

is a hormonal imbalance during this four-week period, gender identity may not develop along the same lines as the genitalia.”); Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3874 (2017) (“Results of studies from a variety of biomedical disciplines — genetic, endocrine, and neuroanatomic — support the concept that gender identity and/or gender expression likely reflect a complex interplay of biological, environmental, and cultural factors.” (footnotes omitted)); Aruna Saraswat et al., *Evidence Supporting the Biologic Nature of Gender Identity*, 21 ENDOCRINE PRAC. 199, 199–202 (2015) (reviewing data supporting “fixed, biologic basis for gender identity,” *id.* at 199, and finding that “[c]urrent data suggest a biologic etiology for transgender identity,” *id.* at 202); *see also* Williams v. Kincaid, 45 F.4th 759, 771 n.7 (4th Cir. 2022) (“[R]ecent medical research suggests ‘that [gender dysphoria] diagnoses have a physical etiology, namely, hormonal and genetic drivers contributing to the in utero development of dysphoria.’” (quoting Doe v. Mass. Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *6 (D. Mass. June 14, 2018))); *id.* (collecting studies supporting genetic basis for sexual differentiation of the brain in utero, contributing to the development of gender dysphoria); Second Statement of Interest of the United States of America at 3–4, Blatt v. Cabela’s Retail, Inc., No. 14-cv-4822 (E.D. Pa. May 18, 2017), 2015 WL 9872493, ECF No. 67 (compiling studies supporting “biologic etiology for transgender identity,” *id.* at 4 (quoting Saraswat et al., *supra*)).

³⁶ JODY L. HERMAN ET AL., WILLIAMS INST., HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? 1 (2022), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf> [<https://perma.cc/8MF3-GXPK>].

³⁷ *See* Am. Psych. Ass’n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 AM. PSYCH. 832, 835 (2015) (“Gender identity is often established in young toddlerhood . . .”).

³⁸ *See* DSM-5, *supra* note 34, at 451; *see also* Kadel v. N.C. State Health Plan for Tchrs. & State Emps., 12 F.4th 422, 427 (4th Cir. 2021); Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 594–95 (4th Cir. 2020).

³⁹ *See* DSM-5, *supra* note 34, at 454–55; *see also* Williams, 45 F.4th at 768 (quoting Grimm, 972 F.3d at 595).

⁴⁰ *See, e.g.*, Bostock v. Clayton County, 140 S. Ct. 1731, 1738 (2020) (acknowledging transgender employee’s diagnosis of gender dysphoria and its medically recommended treatment — gender transition — in case alleging discrimination under Title VII); Williams, 45 F.4th at 768 (concluding that gender dysphoria “can cause, among other things, depression, substance use, self-mutilation, other self-harm, and suicide” and may constitute a disability under the Americans with Disabilities Act and Rehabilitation Act (quoting Grimm, 972 F.3d at 595)); Kadel, 12 F.4th at 423, 427

Like many other serious medical conditions, gender dysphoria is highly treatable and can be cured through a recognized treatment protocol.⁴¹ As Ashley notes, the international medical professional association focused on transgender health needs, the World Professional Association for Transgender Health (WPATH), has established internationally accepted Standards of Care (WPATH Standards)⁴² for the treatment of gender dysphoria.⁴³ The WPATH Standards “represent the consensus approach of the medical and mental health community” regarding the treatment of gender dysphoria and inform medical treatment in the United States and throughout the world.⁴⁴

(recognizing that gender dysphoria is a serious medical condition that may require coverage of “important and sometimes lifesaving” gender-confirming healthcare, *id.* at 427, in case alleging discrimination under Title IX, section 1557 of the Affordable Care Act, and the Equal Protection Clause); *Grimm*, 972 F.3d at 616, 619 (recognizing that gender dysphoria is a serious medical condition that gives rise to a “serious medical need,” *id.* at 619, for access to restrooms consistent with one’s gender identity in case alleging discrimination under Title IX and the Equal Protection Clause); *O’Donnabhain v. Comm’r*, 134 T.C. 34, 61, 77 (2010), *acq.*, 2011-47 I.R.B. 789 (Nov. 21, 2011) (holding that gender identity disorder (GID) “is a serious, psychologically debilitating condition,” *id.* at 61, within the meaning of the Tax Code and that the costs of gender-transition surgery are deductible — a decision in which the IRS subsequently acquiesced); *id.* at 62 (collecting cases holding that GID poses a “serious medical need” for purposes of Eighth Amendment); *Smith v. City of Salem*, 378 F.3d 566, 568 (6th Cir. 2004) (acknowledging transgender employee’s GID diagnosis and her transition to living as a woman “on a full-time basis” — including at work — in accordance with international medical protocols for treating GID” in case alleging discrimination under Title VII and Equal Protection Clause); *Blackwell v. U.S. Dep’t of the Treasury*, 656 F. Supp. 713, 715 (D.D.C. 1986) (holding that plaintiff, a transgender woman who underwent transition, had a medical condition protected under the Rehabilitation Act), *aff’d in part, vacated in part on other grounds*, 830 F.2d 1183 (D.C. Cir. 1987); *Doe v. U.S. Postal Serv.*, Civ. A. No. 84-3296, 1985 WL 9446, at *1-3 (D.D.C. June 12, 1985) (holding that plaintiff, a transgender woman with a “medically and psychologically established need for gender reassignment surgery,” *id.* at *1, had a medical condition protected under the Rehabilitation Act); *Doe v. McConn*, 489 F. Supp. 76, 77, 79-81 (S.D. Tex. 1980) (holding that City of Houston’s “cross-dressing” ban violated the substantive due process rights of people undergoing a “medically and psychologically necessary” transition, *id.* at 79, to treat “gender identity disturbance,” *id.* at 77).

⁴¹ See WPATH STANDARDS, *supra* note 1, at 5 (“Gender dysphoria can in large part be alleviated through treatment.” (citation omitted)); *Grimm*, 972 F.3d at 595 (“Fortunately, we now have modern accepted treatment protocols for gender dysphoria.” (citing WPATH STANDARDS, *supra* note 1)); *accord Williams*, 45 F.4th at 764 (“People suffering from gender dysphoria often benefit from medical treatment, including hormone therapy.”); DSM-5, *supra* note 34, at 451 (stating that “many [individuals] are distressed if the desired physical interventions by means of hormones and/or surgery are not available” (emphasis added)). WPATH recently issued a draft of an eighth edition of its Standards of Care, which it finalized in September 2022. *WPATH Standards Version 8, supra* note 12.

⁴² See generally WPATH STANDARDS, *supra* note 1.

⁴³ *Mission and Vision*, WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, <https://wpath.org/about/mission-and-vision> [<https://perma.cc/B69N-4BKW>]; see also WPATH STANDARDS, *supra* note 1, at 1 (“promot[ing] the highest standards of health care for individuals . . . based on the best available science and expert professional consensus”).

⁴⁴ *Grimm*, 972 F.3d at 595 (stating that the WPATH Standards “have been recognized by various courts, including this one, as the authoritative standards of care”); *accord Williams*, 45 F.4th at 767 n.3; *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019); *O’Donnabhain*, 134 T.C. at 37-38, 65; see also *Adams ex rel. Kasper v. Sch. Bd.*, 968 F.3d 1286, 1293 (11th Cir. 2020) (referencing standards of care for gender dysphoria); *Fields v. Smith*, 653 F.3d 550, 553-54 (7th Cir. 2011) (same).

Pursuant to the WPATH Standards, individuals with gender dysphoria undergo a medically established and supervised gender transition in order to live consistently with their gender identity.⁴⁵ Because the essence of gender dysphoria is the incongruence of the body and one's identity, the goal of gender transition is to enable the person to comfortably live in their affirmed gender in order to eliminate the debilitating symptoms of gender dysphoria.⁴⁶ If this goal is impeded — if a person is denied access to gender-transition care — it will undermine an individual's core identity and “expose transgender individuals to a serious risk of psychological and physical harm.”⁴⁷

The current WPATH Standards recommend an individualized approach to gender transition consisting of one or more of the following evidence-based treatment options for gender dysphoria: social transition, hormone therapy, counseling, and transition surgery.⁴⁸ Despite incorporation of the word “social” in its description, social transition is part of the medical course of gender transition.⁴⁹ It refers to changes in an individual's gender expression and role, which involve living in the gender role consistent with one's gender identity.⁵⁰ Hormone therapy refers to “the administration of exogenous endocrine agents to induce feminizing or masculinizing changes,” such as a deepened voice, growth in facial and body hair, cessation of menses, physical alteration of sex-related physiology, and decreased percentage of body fat compared to muscle mass in transgender men, as well as alterations to a person's genital appearance and functionality, breast development, and increased percentage of body fat compared to muscle mass in transgender women.⁵¹

The WPATH Standards include counseling among treatment options, but, critically, counseling (individual, couple, family, or group) “is not intended to alter a person's gender identity” but rather is intended to help people “achieve long-term comfort in their gender identity expression” by: exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support;

⁴⁵ See WPATH STANDARDS, *supra* note 1, at 9–10.

⁴⁶ See Affidavit of Randi Ettner ¶ 13, Health Insurers' Categorization of Certain Gender Confirming Surgeries as Cosmetic (Conn. Comm'n on Hum. Rts. & Opportunities Jan. 28, 2020).

⁴⁷ *Williams*, 45 F.4th at 768 (quoting *Edmo*, 935 F.3d at 771); Affidavit of Randi Ettner, *supra* note 46, ¶ 13; see also Boulware et al., *supra* note 1 (manuscript at 13) (“The scientific consensus is clear: denying gender-affirming care harms transgender people and puts their lives at risk.”).

⁴⁸ See WPATH STANDARDS, *supra* note 1, at 9–10.

⁴⁹ See *id.*

⁵⁰ *Id.*; see also Am. Psych. Ass'n, *supra* note 37, at 863 (defining social transition); Hembree et al., *supra* note 35, at 3877 (same). See generally Heath Mackenzie Reynolds & Zil Garner Goldstein, *Social Transition*, in TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY 124, 124–54 (Laura Erickson-Schroth ed., 2014).

⁵¹ WPATH STANDARDS, *supra* note 1, at 33, 36; see also Hembree et al., *supra* note 35, at 3885–89 (discussing hormone therapy).

improving body image; or promoting resilience.⁵² Lastly, transition surgery refers to a range of procedures that change one's primary and/or secondary sex characteristics, including surgery on the breasts or chest, external or internal genitalia, and facial features.⁵³

Contrary to the claims of some opponents of gender-transition care,⁵⁴ gender transition is age dependent. For children (prepubertal youth) and adolescents (postpubertal youth), gender transition includes counseling and/or social transition to assist with the exploration and affirmation of gender identity and the alleviation of distress.⁵⁵ For adolescents, a staged process of medical interventions may also be indicated, beginning with puberty-blocking medication and proceeding, in appropriate cases, to hormone therapy.⁵⁶ Children are not eligible for genital surgery under accepted standards, and chest surgery for adolescent transgender men is recommended only "after ample time of living in the desired gender role and after one year of testosterone treatment."⁵⁷ For adults, the WPATH Standards recommend a combination of counseling, social transition, hormone therapy, and/or surgery, in each case based on the individual's needs.⁵⁸

While noting that gender-transition care is safe, effective, and medically necessary — and that conversion practices are *not* — Ashley cites several medical professionals, including Dr. Kenneth Zucker, who argue that there is no consensus over the best treatment for transgender youth, particularly prepubertal youth (pp. 30–31, 88).⁵⁹ This is not the case.

For example, the WPATH Standards and Endocrine Society Guidelines, both of which are based on reviews of the best available science and expert consensus across medical disciplines, recommend mental health counseling and/or social transition to assist prepubertal children in exploring and affirming their gender identity.⁶⁰ According

⁵² WPATH STANDARDS, *supra* note 1, at 29; *see also* Am. Psych. Ass'n, *supra* note 37, at 847 (discussing provision of gender-transition care through assessment and psychotherapy).

⁵³ WPATH STANDARDS, *supra* note 1, at 57–58.

⁵⁴ *See, e.g.*, Boulware et al., *supra* note 1 (manuscript at 2) (discussing Texas and Alabama government officials' "exaggerated and unsupported claims about the course of treatment for gender dysphoria, specifically claiming that standard medical care for pediatric patients includes surgery on genitals and reproductive organs. In fact, the authoritative protocols for medical care for transgender children and adolescents . . . specifically state that individuals must be over the age of majority before they can undergo such surgery.").

⁵⁵ *See WPATH Standards Version 8, supra* note 12, at S48, S69; WPATH STANDARDS, *supra* note 1, at 14–16; *see also* Hembree et al., *supra* note 35, at 3870–71.

⁵⁶ WPATH STANDARDS, *supra* note 1, at 18–21; *see also* Hembree et al., *supra* note 35, at 3871.

⁵⁷ WPATH STANDARDS, *supra* note 1, at 21; *see also* Hembree et al., *supra* note 35, at 3872.

⁵⁸ WPATH STANDARDS, *supra* note 1, at 9–10; *see, e.g.*, Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 596 (4th Cir. 2020) (discussing WPATH Standards' treatment options for gender dysphoria).

⁵⁹ *See* Am. Psych. Ass'n, *supra* note 37, at 842 (citing Zucker in support of approach that encourages children to "align with their sex assigned at birth").

⁶⁰ *See supra* p. 1121 (discussing treatment of children pursuant to WPATH Standards and Endocrine Society Clinical Practice Guideline).

to the eighth version of the WPATH Standards, social transition, when desired and appropriate for the child, should be allowed and best serves the child's interests.⁶¹ For adolescents with gender dysphoria, the weight of scientific evidence indicates that some combination of counseling, social transition, and transitioning medications improves overall well-being.⁶² For example, eight studies investigating the use of puberty-blocking medication on adolescents with gender dysphoria, and six studies investigating the use of hormone therapy to treat adolescents with gender dysphoria, have all found "positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation."⁶³ As a 2022 report by medical and legal experts from the Yale School of Medicine's Child Study Center and Departments of Psychiatry and Pediatrics, the University of Texas Southwestern, and Yale Law School (Yale Report) concludes: "A solid body of reliable research has shown that . . . gender-affirming [medical] care for adolescents with gender dysphoria — puberty-blocking medications and hormone therapy — have major mental-health benefits, including higher levels of general well-being and significantly decreased levels of suicidality."⁶⁴

⁶¹ *WPATH Standards Version 8*, *supra* note 12, at S69, S76 (stating that "parents/caregivers and health care professionals" should "respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity," *id.* at S69, and that "recognition that a child's gender may be fluid and develop over time . . . is not sufficient justification to negate or deter social transition for a prepubescent child when it would be beneficial," *id.* at S76 (citation omitted)).

⁶² See *supra* p. 1121 (discussing treatment of adolescents pursuant to WPATH Standards and Endocrine Society Clinical Practice Guideline).

⁶³ Brief of Amici Curiae American Academy of Pediatrics et al. in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction at 14–16, *Eknes-Tucker v. Marshall*, No. 22-cv-184 (M.D. Ala. May 13, 2022) [hereinafter Brief of Amici Curiae American Academy of Pediatrics et al.] (citing 2020 study finding that transgender adults who received puberty-blocking hormone treatment while adolescents "had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support," *id.* at 15, and that "[a]pproximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation," *id.*; citing 2019 longitudinal study finding that gender-transition hormone treatment resulted in statistically significant decrease in suicidality among transgender adolescents, *id.* at 16; citing 2011 prospective two-year follow-up study of adolescents with gender dysphoria, which found that puberty-blocking medication was associated with decreased depression and improved overall functioning, *id.*; and citing six-year follow-up study of individuals from the 2011 study, finding that subsequent treatment with hormone therapy and surgery in adulthood "was associated with a statistically significant decrease in depression and anxiety" and "a sense of well-being that was equivalent or superior to that seen in age-matched [nontransgender] controls from the general population," *id.*).

⁶⁴ Boulware et al., *supra* note 1 (manuscript at 14); see also sources cited *supra* note 63 (discussing scientific studies supporting the safety and efficacy of gender-transition care).

B. Conflating Identity and Diagnosis

As the above discussion illustrates, being transgender is not itself a health condition. “Having a gender identity that differs from the gender we were assigned at birth,” Ashley writes, “is a normal and positive variant of human gender subjectivity and is not an indicator of mental disorder” (p. 47). Because transgender identity is not a health condition, its presence alone does not indicate treatment. Gender dysphoria, by contrast, *is* a health condition,⁶⁵ and its treatment is gender transition.⁶⁶

For many decades, the medical literature did not clearly distinguish between transgender identity and health conditions. As the Fourth Circuit explained in *Grimm v. Gloucester County School Board*,⁶⁷ “being transgender was pathologized for many years. As recently as the third and fourth editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III and DSM-IV), one could receive a diagnosis of ‘transsexualism’ or ‘gender identity disorder,’ indicat[ing] that the clinical problem was the discordant gender identity.”⁶⁸ In 2013, the fifth edition of the DSM replaced “gender identity disorder” with “gender dysphoria.”⁶⁹ As the Fourth Circuit stated in the landmark case of

⁶⁵ There are divergent views on whether gender dysphoria is properly characterized as a “physical” or “mental” health condition. The World Health Organization’s International Classification of Diseases, for example, classifies “gender incongruence” as a “Condition[] related to sexual health,” not a “[m]ental and behavioural disorder[.]” *Gender Incongruence and Transgender Health in the ICD*, WORLD HEALTH ORG., <https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd> [<https://perma.cc/8SCG-AG52>] (“Gender incongruence has been moved out of the ‘Mental and behavioural disorders’ chapter and into the new ‘Conditions related to sexual health’ chapter” to “reflect[] current knowledge that trans-related and gender diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma.”). There is a growing understanding that health conditions that manifest with mental health consequences are physical in origin. See, e.g., Duffy, *supra* note 35, at 16–51 (discussing “conditions that have unknown etiologies or that are thought to result from and/or be exacerbated by a combination of congenital, genetic, hormonal, neurological, and/or social-interaction factors,” including stuttering and Tourette syndrome, both of which “were once believed to simply be psychiatric conditions”). In the United States, gender dysphoria is currently classified as a mental health condition. DSM-5, *supra* note 34, at 451. Because gender dysphoria is already understood to have a physiologic origin and is treated with nonpsychiatric modalities such as hormones and surgery, it may, at some point in the future, be classified as a physical diagnosis. See, e.g., *Doe v. Mass. Dep’t of Corr.*, No. 17-12255, 2018 WL 2994403, at *6 (D. Mass. June 14, 2018) (“While medical research in this area remains in its initial phases . . . recent studies demonstrat[e] that [gender dysphoria] diagnoses have a physical etiology, namely hormonal and genetic drivers contributing to the in utero development of dysphoria.”).

⁶⁶ See *supra* p. 1120 (discussing gender dysphoria and its treatment).

⁶⁷ 972 F.3d 586 (4th Cir. 2020).

⁶⁸ *Id.* at 611 (alteration in original); see also *Tingley v. Ferguson*, 47 F.4th 1055, 1064 (9th Cir. 2022) (stating that the professional psychiatric and psychological community’s view of “gender-nonconforming behaviors . . . as mental illnesses” has “evolved with time and research,” and discussing the American Psychological Association’s elimination of “gender identity disorder”).

⁶⁹ See DSM-5, *supra* note 34, at 451 (“The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.”).

Williams v. Kincaid,⁷⁰ which recognized gender dysphoria as a protected disability under disability rights laws,⁷¹ this shift in language was meaningful:

[I]n 1990, the gender identity disorder diagnosis marked being transgender as a mental illness. . . . [A] diagnosis of gender dysphoria, [by contrast], concerns itself primarily with *distress* and other disabling symptoms, rather than simply being transgender. . . . Put simply, while the older DSM pathologized the very existence of transgender people, the recent DSM-5's diagnosis of gender dysphoria takes as a given that being transgender is not a disability and affirms that a transgender person's medical needs are just as deserving of treatment and protection as anyone else's.⁷²

Ashley underscores this meaningful difference. “By abandoning the terminology of ‘Gender Identity Disorder’ in favour of ‘Gender Dysphoria,’” they write, “the fifth edition of the DSM expresses the view that although trans people may experience clinically significant distress, their gender identity is not pathological but, rather, part of normal human diversity” (p. 91).⁷³

Notwithstanding this change in diagnosis, proponents of conversion practices erroneously — and deliberately — conflate transgender identity and gender dysphoria. As Ashley explains, conversion practices are predicated on the view “that being trans or transitioning is pathological, undesirable, and something to be avoided” (p. 32). From the false premise “that there is something wrong or undesirable about being trans, proponents of conversion practices conclude that they should prevent people from being trans and transitioning socially or medically to live in their desired body and gender” (p. 11).

II. THE HARM OF CONVERSION PRACTICES

As Ashley states, conversion practices harm transgender people in several ways. First, they write, these practices “persistently invalidate a core aspect of one’s personal identity and self-knowledge” (p. 11). By discouraging behaviors and identities not associated with one’s assigned birth sex, conversion practices teach transgender people “to be ashamed of themselves and of who they are, leading to anxiety, depression, and suicidality” (p. 11). To illustrate the concrete harms of conversion practices, Ashley quotes several survivors of conversion practices, who

⁷⁰ 45 F.4th 759 (4th Cir. 2022).

⁷¹ *Id.* at 773.

⁷² *Id.* at 767–69; *see also id.* at 769 (“The obsolete diagnosis focused solely on cross-gender identification; the modern one on clinically significant distress.”).

⁷³ The author states that the DSM’s “shift in language” was “motivated by the need to de-pathologize people whose gender identity does not correspond to the gender they were assigned at birth” (p. 91). *See also* Eric Yarbrough et al., *Gender Dysphoria Diagnosis*, AM. PSYCHIATRIC ASS’N (Nov. 2017), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis> [https://perma.cc/T8YX-CHBU] (same).

explain that the psychological “treatment” they received was, in fact, “child abuse” that led to self-loathing, shame, depression, and suicidality (pp. 11, 41).⁷⁴

The heartbreaking accounts of survivors of conversion practices are remarkably consistent across the country and throughout the world and are strong evidence of the harms of such practices. Although Ashley thoughtfully acknowledges these personal experiences, they do not delve deeply into them (pp. 17–18).⁷⁵ We think a fuller discussion of survivors’ experiences would be helpful to Ashley’s argument that conversion practices are harmful, and so we survey some of those experiences here.

We begin with Liam’s story. At twenty-one, Liam confided in his pastor about struggling with his gender identity and sexuality.⁷⁶ Liam’s pastor offered him support, which took the form of conversion practices.⁷⁷ “I didn’t realise at first that this ‘help’ was intended to prevent me from transitioning and end my relationships with women,” Liam recalls.⁷⁸ Over the course of several months, “the pastor, along with his wife and a counselor they provided (who was also a member of the church) did all they could to convince [Liam] that it was wrong to be trans, and wrong to be attracted to women.”⁷⁹ They told Liam that he had “embraced a lie from the devil,” cited scriptures that were said to prove “God’s design was for cis, heterosexual men and women,” warned Liam that transitioning and having intimate relationships with women would result in his “going to hell,” and told him “not to have [chest] surgery and to leave [his] body alone.”⁸⁰

Instead of support and acceptance, Liam “was left with feelings of rejection and not being ‘good enough,’” shame regarding his sexuality and gender identity, and “the fear that [he would] go to hell.”⁸¹ According to Liam:

One of the most destructive impacts was that I began to believe I was unlovable. After all, if I was being told that even God couldn’t bear who I

⁷⁴ Ashley discusses the experiences of Professor Sé Sullivan, Professor Karl Bryant, and Erika Muse (pp. 11, 16–17). See also NCLR & HRC REPORT, *supra* note 17, at 11 (“[S]urvivors 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. . . . 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.”).

⁷⁵ Ashley declines to “extensively argu[e] . . . that it is wrong to seek to prevent people from being trans” and instead points the reader to their own and others’ helpful work on the topic (pp. 17–18).

⁷⁶ *Liam’s Story*, BAN CONVERSION THERAPY, <https://www.banconversiontherapy.com/liams-story> [<https://perma.cc/BV4M-589R>].

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

am, then it was, and sometimes still is, difficult to see how I am worthy of love. . . . It has been really difficult to shake off the idea that that there's something wrong with me⁸²

Liam's story is not unique. There are, unfortunately, countless stories like his. According to survivors, conversion practitioners routinely attempt to locate the cause of LGBTQ identity in an unpleasant experience or trauma, or, as in Liam's case, sin.⁸³ Survivors report being told that their sexual orientation or gender identity was caused by everything from overbearing mothers and distant fathers (echoing the discredited work of child psychologist Bruno Bettelheim, who "blamed cold, distant 'refrigerator mothers' for everything from autism to schizophrenia in their children"⁸⁴) to bullying by members of the same sex, being rejected by members of the opposite sex, lack of athletic ability, social and psychological immaturity,⁸⁵ and "a bad spirit that need[s] to be prayed out."⁸⁶ Dr. Kenneth Zucker, a controversial figure in the medical community whose gender identity clinic in Toronto was closed in 2015 after an external review concluded that it was "out of step with current clinical and operating practices" (pp. 3, 5), has similarly suggested that transgender identity could be the result of neglectful parents, domineering older sisters, or a mother who delayed naming a newborn son.⁸⁷

With this pathological foundation laid, conversion practitioners tell patients that their sexual orientation or gender identity can be cured by bizarre, humiliating, and brutal behavioral conditioning. Examples include: "[w]atching heterosexual pornography";⁸⁸ "[m]asturbating to pictures of the opposite sex"; participating in "exorcism-like rituals,"⁸⁹ such as "the laying on of hands,"⁹⁰ repeatedly shouting prayers, and telling

⁸² *Id.*

⁸³ *See id.*; *see also* Hannah Rosin, *A Boy's Life*, THE ATLANTIC, Nov. 2008, at 56, 67–70, <https://www.theatlantic.com/magazine/archive/2008/11/a-boys-life/307059> [<https://perma.cc/FH2M-Y3RH>].

⁸⁴ Rosin, *supra* note 83, at 70.

⁸⁵ *An Act Concerning the Protection of Youth from Conversion Therapy: Hearing on H. 6695 Before the J. Comm. on Pub. Health*, 2017 Gen. Assemb., Reg. Sess. 1, 8 n.14 (Conn. 2017) [hereinafter *Clinic Testimony*] (statement of Quinnipiac Univ. Sch. of L. Civ. Just. Clinic) (citing survivors of conversion practices Maxwell Hirsh, Curtis Gallaway, and Norman Birthmark), <https://www.cga.ct.gov/2017/PHdata/Tmy/2017HB-06695-R000307-Quinnipiac%20University%20School%20of%20Law%20Civil%20Justice%20Clinic%20-TMY.PDF> [<https://perma.cc/PRA5-HCQJ>]; *see also* Rosin, *supra* note 83, at 68–69.

⁸⁶ *Liam's Story*, *supra* note 76.

⁸⁷ Rosin, *supra* note 83, at 68–69. Ashley also states that conversion practitioners frequently identify "parents (and especially mothers) . . . as a contributing cause of gender creativity in children" (p. 29).

⁸⁸ *Clinic Testimony*, *supra* note 85, at 2.

⁸⁹ *Id.*

⁹⁰ *George's Story*, BAN CONVERSION THERAPY, <https://www.banconversiontherapy.com/george-story> [<https://perma.cc/X3RK-JM6V>]; *see also* Eleanor Lawrie, "I Was Told I'd Be Delivered from Homosexuality," BBC NEWS (Oct. 29, 2021), <https://www.bbc.com/news/uk-59066204> [<https://perma.cc/ZK3H-EH83>].

the “gay part” of oneself to leave one’s body;⁹¹ “[w]earing a rubber band around one’s wrist and snapping it when one thinks of the same sex”;⁹² “[b]eing punched when one ‘acts’ like the opposite sex”;⁹³ “[b]eing taunted with homophobic slurs”;⁹⁴ “[s]pending more time at the gym and being naked with one’s father at bathhouses”;⁹⁵ “[b]eating an effigy of one’s mother with a tennis racket while screaming, as if killing her”;⁹⁶ “[r]eenacting scenes of past abuse in front of others”;⁹⁷ “[d]isrobing and touching one’s genitals and buttocks”;⁹⁸ viewing pictures of same-sex couples while holding ice or hot coils or being given electric shocks;⁹⁹ and “endur[ing] isolation in locked rooms.”¹⁰⁰

Less shocking but equally harmful practices include psychotropic medication, hypnosis to redirect desires and arousal, and, as in Liam’s case, “talk therapy” aimed at conforming one’s sexual orientation or gender identity with stereotypical gender norms.¹⁰¹ During talk-therapy

⁹¹ *Conversion Therapy: Gay Man Talks of Church “Exorcism” Trauma*, BBC NEWS (Feb. 2, 2022), <https://www.bbc.com/news/uk-england-south-yorkshire-60208017> [<https://perma.cc/5HWM-SLRZ>].

⁹² *Clinic Testimony*, *supra* note 85, at 2; KORI CORDERO & VANESSA CARLISLE, AM. BAR ASS’N, COMM’N ON SEXUAL ORIENTATION & GENDER IDENTITY, BANNING CONVERSION THERAPY ON MINORS: A GUIDE FOR CREATING TRIBAL AND STATE LEGISLATION 2 (2019), https://www.americanbar.org/content/dam/aba/administrative/sexual_orientation/banning-conv-ther-leg-resource-1-14-19draft.pdf [<https://perma.cc/6YDP-NGW7>].

⁹³ *Clinic Testimony*, *supra* note 85, at 2.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ ImFromDriftwood, *Sam Brinton (I’m From Perry, IA) Part 1 – True LGBT Stories*, YOUTUBE, at 01:26–02:14 (Oct. 1, 2010), <https://www.youtube.com/watch?v=usGKHdC19Mo> [<https://perma.cc/MPG4-V7TP>]; CORDERO & CARLISLE, *supra* note 92, at 2.

¹⁰⁰ CORDERO & CARLISLE, *supra* note 92, at 2. Many other survivors of conversion practices have come forward to describe the brutality they have experienced. See, e.g., NCLR & HRC REPORT, *supra* note 17, at 7; AM. PSYCH. ASS’N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22, 31 (2009), <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf> [<https://perma.cc/B52V-EAVR>]; Lawrie, *supra* note 90; Rachel Savage, *LGBT+ Conversion Therapy Survivors Share Stories on TikTok*, REUTERS (Aug. 18, 2020, 11:00 AM), <https://www.reuters.com/article/us-usa-lgbt-tech/lgbt-conversion-therapy-survivors-share-stories-on-tiktok-idUSKCN25E226> [<https://perma.cc/3Y48-63D3>]; Kate McCobb, *I Survived Eight Years of Conversion Therapy. But I Fought Back.*, NAT’L CTR. FOR LESBIAN RTS. (Mar. 20, 2019), <https://www.nclrights.org/fi-survived-eight-years-of-conversion-therapy-but-i-fought-back> [<https://perma.cc/6QUC-X2V6>]; James Guay, *My Hellish Youth in Gay Conversion Therapy and How I Got Out*, TIME (July 15, 2014, 11:50 AM), <https://time.com/2986440/sexual-conversion-therapy-gay> [<https://perma.cc/P552-JY2F>]; ImFromDriftwood, *Sam Brinton (I’m From Perry, IA) Part 2 – True LGBT Stories*, YOUTUBE (Oct. 5, 2010), <https://www.youtube.com/watch?v=15M-BIUUc5k> [<https://perma.cc/T4RU-4Z9H>]. See generally *Born Perfect*, NAT’L CTR. FOR LESBIAN RTS., <https://www.nclrights.org/our-work/born-perfect> [<https://perma.cc/F88D-TYYF>] (collecting testimonials of survivors of conversion practices); *Stories*, BAN CONVERSION THERAPY, <https://www.banconversiontherapy.com/stories> [<https://perma.cc/3WDQ-6DBE>] (same).

¹⁰¹ NCLR & HRC REPORT, *supra* note 17, at 7; ABA RESOLUTION, *supra* note 17, at 2; *Liam’s Story*, *supra* note 76.

sessions, survivors report being told that they are “sick,”¹⁰² that they will get AIDS and die,¹⁰³ that they will go to hell,¹⁰⁴ and that being gay or transgender is an abomination that will lead to “misery”¹⁰⁵ and a life of loneliness with no family or children.¹⁰⁶ Survivors are encouraged to blame LGBTQ identity on distant fathers and over-involved mothers;¹⁰⁷ “to ‘remember’ an original wounding — in particular, sexual or physical abuse” — that never, in fact, took place;¹⁰⁸ and to date members of the opposite sex, build “healthy same-sex non-sexual friendships,” and become more stereotypically masculine or feminine.¹⁰⁹

Being “made to feel broken or wrong for being as [you] are, with practitioners acting as if they are trying to repair or fix [you],” Ashley writes, is psychologically devastating (p. 23). Survivors of conversion practices consistently report feeling suicidal and engaging in self-harm; hating themselves and feeling worthless, guilty, lonely, and ashamed; experiencing anxiety and depression; and developing eating disorders and engaging in high-risk sexual activity and substance abuse.¹¹⁰ “I tried to kill myself,” “I [didn’t] want to live,” “I started to self-harm,” “I’m worthless,” “I hate myself,” and “[I] still have flashbacks,” are tragically familiar refrains.¹¹¹

Second, and relatedly, by promoting harmful and scientifically invalid practices in the guise of treatment, conversion practices delay or foreclose safe and effective treatment for gender dysphoria — namely, social and medical transition.¹¹² “For those who undergo conversion practices before or during puberty,” Ashley explains, “this can mean undergoing undesired, difficult-to-reverse, and deeply distressing bodily changes” (p. 12). In this additional way, conversion practices are particularly brutalizing; they “condemn[] trans people . . . to the experience of ongoing

¹⁰² McCobb, *supra* note 100.

¹⁰³ *Clinic Testimony*, *supra* note 85, at 2.

¹⁰⁴ See Savage, *supra* note 100.

¹⁰⁵ Guay, *supra* note 100.

¹⁰⁶ *Clinic Testimony*, *supra* note 85, at 2.

¹⁰⁷ *Id.* at 1.

¹⁰⁸ Guay, *supra* note 100.

¹⁰⁹ See *id.*; McCobb, *supra* note 100. See generally sources cited *supra* note 100 (collecting sources discussing survivors’ accounts of conversion practices).

¹¹⁰ See NCLR & HRC REPORT, *supra* note 17, at 12; ABA RESOLUTION, *supra* note 17, at 2–5; *Seven Survivors of Conversion Therapy Describe Its Lasting, Damaging Impact*, STONEWALL (Sept. 28, 2021), <https://www.stonewall.org.uk/about-us/news/seven-survivors-conversion-therapy-describe-its-lasting-damaging-impact> [<https://perma.cc/FJ3B-3UYQ>]; Lawrie, *supra* note 90; Guay, *supra* note 100; *Clinic Testimony*, *supra* note 85, at 2 (describing survivors’ accounts of conversion practices). See generally *Born Perfect*, *supra* note 100 (same); *Stories*, *supra* note 100 (same).

¹¹¹ *Seven Survivors of Conversion Therapy Describe Its Lasting, Damaging Impact*, *supra* note 110; *Emily’s Story*, BAN CONVERSION THERAPY, <https://www.banconversiontherapy.com/emilys-story> [<https://perma.cc/89UJ-3QMR>]; *Clinic Testimony*, *supra* note 85, at 2; see also *Born Perfect*, *supra* note 100 (compiling stories of survivors of conversion practices); *Stories*, *supra* note 100 (same). Ashley also collects survivors’ stories (pp. 82, 211 n.32).

¹¹² See Boulware et al., *supra* note 1 (manuscript at 12–15); see also *supra* section I.A, pp. 1117–22 (discussing gender-transition treatment).

suffering” by also withholding medically necessary care (p. 12). As the 2022 Yale Report concludes, the harms associated with not providing gender-transition care are empirically based: “40% of trans individuals who do not receive hormones will attempt or complete suicide in their lifetime.”¹¹³

Third, as Ashley writes, conversion practices are “part of a larger social project of oppressing and discrediting trans communities” and making transgender people invisible (p. 13). This is not an overstatement. By depicting transgender identity as pathological and something to be eradicated, conversion practices seek the erasure of transgender people (p. 28).¹¹⁴ Ashley quotes proponents of conversion practices, such as former Centre for Addiction and Mental Health (CAMH) clinic director Dr. Kenneth Zucker and his colleagues, who “presume[] cisgender identification to be desirable,” and who seek “to reduce . . . cross-gender identification” in children, thereby “preventing the future need for hormonal intervention and protecting the child from the stigma of being a transgender individual” (pp. 27–28).¹¹⁵ According to Zucker, preventing a child from being transgender is akin to preventing a child from wanting to amputate a healthy limb, believing they are a cat, or wanting to be a different race.¹¹⁶ Prevention of cross-gender identification in adulthood is, to Zucker and his colleagues, “obviously clinically valid and consistent with the ethics of our time” (p. 28).¹¹⁷

By seeking to prevent people from being transgender, conversion practices legitimate “harassment, discrimination, and violence against trans people” by mainstream society (p. 13). They do so by fueling the false narrative that gender-transition care is “dangerous” and “radical”; that conversion practices should be encouraged; and that society is in

¹¹³ Boulware et al., *supra* note 1 (manuscript at 12).

¹¹⁴ Ashley states that “[t]rans conversion practices are fundamentally transantagonistic” and “symbolize the dehumanization and devaluation of trans people” (p. 13). Similarly, conversion practitioners’ desire for children “to become comfortable in their skin and in the gender/sex they were assigned at birth . . . is just another way of saying that they do not want children to be trans or to grow up to be trans” (p. 28).

¹¹⁵ Ashley quotes Jack L. Turban III, Annelou L.C. de Vries & Kenneth J. Zucker, *Gender Dysphoria and Gender Incongruence*, in LEWIS’S CHILD AND ADOLESCENT PSYCHIATRY 632, 639 (Andrés Martin et al. eds., 2018); they also quote Jack L. Turban & Diane Ehrensaft, *Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies*, 59 J. CHILD PSYCH. & PSYCHIATRY 1228, 1235 (2018) (pp. 27–28, 202 nn.22 & 25).

¹¹⁶ Rosin, *supra* note 83, at 68.

¹¹⁷ Ashley quotes KENNETH J. ZUCKER & SUSAN J. BRADLEY, GENDER IDENTITY DISORDER AND PSYCHOSEXUAL PROBLEMS IN CHILDREN AND ADOLESCENTS 269 (1995) (p. 202 n.23). See Am. Psych. Ass’n, *supra* note 37, at 842 (citing work of Zucker and colleagues in support of approach that encourages children “to embrace their given bodies and to align with their assigned gender roles. This includes endorsing and supporting behaviors and attitudes that align with the child’s sex assigned at birth prior to the onset of puberty. Clinicians using this approach believe that undergoing multiple medical interventions and living as a [transgender and gender nonconforming (TGNC)] person in a world that stigmatizes gender nonconformity is a less desirable outcome than one in which children may be assisted to happily align with their sex assigned at birth.” (citations omitted)).

the midst of an “unprecedented epidemic” of “rapid-onset gender dysphoria” among youth “who falsely believ[e] themselves to be transgender due to ‘social contagion’ and unexamined mental illness and trauma,” as well as medical professionals “aggressively pushing for interventions on minors” (pp. 14–16).¹¹⁸

To be clear, there is no epidemic of so-called “rapid-onset gender dysphoria” that is leading teenagers to falsely claim they are transgender based on peer influence.¹¹⁹ As the 2022 Yale Report concludes, this sensational claim derives from a poor-quality study conducted in 2018 that has since “been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites.”¹²⁰ No reputable professional organization has recognized rapid-onset gender dysphoria as a distinct clinical diagnosis, and studies of clinical data provide no support for the diagnosis.¹²¹ The increase in the number of referrals to gender clinics in recent years is attributable not to a novel condition infecting the nation’s youth, but rather to a reduction in social stigma against transgender people, an increase in public awareness of gender dysphoria, and an expansion in access to gender-transition care.¹²²

The harms of conversion practices are widely recognized by authoritative bodies in the United States and throughout the world. The overwhelming consensus position of the national and international medical community is that conversion practices are neither safe nor effective (p. 14). According to the WPATH Standards of Care, “[t]reatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success, particularly in the long term,” “is no longer considered ethical”¹²³ and “may be viewed as a form of violence.”¹²⁴ The U.S. Substance Abuse and Mental Health Services Administration has likewise concluded that conversion practices are “not supported by credible evidence” — that is, “none of the existing research supports the premise that mental or behavioral health interventions can alter gender

¹¹⁸ Brief of Amici Curiae American Academy of Pediatrics et al., *supra* note 63, at 18; Boulware et al., *supra* note 1 (manuscript at 19–21); Jo Yurcaba, *Alabama Governor Signs Bill Criminalizing Transgender Health Care for Minors*, NBC NEWS (Apr. 8, 2022, 5:22 PM), <https://www.nbcnews.com/nbc-out/out-politics-and-policy/alabama-governor-signs-bill-criminalizing-transgender-health-care-mino-rcna23674> [<https://perma.cc/DR4B-8FY9>].

¹¹⁹ See Boulware et al., *supra* note 1 (manuscript at 19–21).

¹²⁰ *Id.* (manuscript at 20).

¹²¹ *Id.* (manuscript at 21).

¹²² *Id.* (manuscript at 20); see also Brief of Amici Curiae American Academy of Pediatrics et al., *supra* note 63, at 18–19. “[A] 2018 study showed that the percentage of patients who presented to a gender clinic for evaluation and received medical interventions has actually *decreased* over time.” Brief of Amici Curiae American Academy of Pediatrics et al., *supra* note 63, at 19.

¹²³ WPATH STANDARDS, *supra* note 1, at 32 (citations omitted).

¹²⁴ WPATH Standards Version 8, *supra* note 12, at S20; see also *id.* at S53, S176 (rejecting conversion practices as unethical and harmful).

identity or sexual orientation” — and that such practices “may put young people at risk of serious harm.”¹²⁵ Decades of scientific research strongly support the view that conversion practices are harmful and ineffective.¹²⁶ As Ashley notes, “[d]epression and suicidality are common

¹²⁵ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., ENDING CONVERSION THERAPY: SUPPORTING AND AFFIRMING LGBTQ YOUTH 1 (Oct. 2015), <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4928.pdf> [<https://perma.cc/3XUQ-ZDMY>].

¹²⁶ See, e.g., *WPATH Standards Version 8*, *supra* note 12, at S53 (“We recommend against [conversion] efforts because they have been found to be ineffective and are associated with increases in mental illness and poorer psychological functioning.” (citations omitted)); Boulware et al., *supra* note 1 (manuscript at 12 n.37) (citing 2019 study showing that conversion practices “create psychological distress and prompt suicide”); MALLORY ET AL., *supra* note 11, at 1 (citing studies demonstrating that “[e]fforts to change someone’s sexual orientation or gender identity are associated with poor mental health, including suicidality”); Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, 67 J. HOMOSEXUALITY 159, 159 (2020) (finding that “[a]ttempts by parents/caregivers and being sent to therapists and religious leaders for conversion interventions were associated with depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income,” and that associations “were much stronger and more frequent for those reporting both attempts by parents and being sent to therapists and religious leaders”); What We Know Project, *What Does the Scholarly Research Say About Whether Conversion Therapy Can Alter Sexual Orientation Without Causing Harm?*, CORNELL UNIV. (2016), <https://whatwewknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-whether-conversion-therapy-can-alter-sexual-orientation-without-causing-harm> [<https://perma.cc/F6K5-HPNS>] (discussing twelve peer-reviewed studies of conversion practices that “concluded that [conversion practices are] ineffective and/or harmful, finding links to depression, suicidality, anxiety, social isolation and decreased capacity for intimacy,” and finding only one study to the contrary — authored, in part, by Joseph Nicolosi, an outspoken proponent of conversion practices, see Richard Sandomir, *Joseph Nicolosi, Advocate of Conversion Therapy for Gays, Dies at 70*, N.Y. TIMES (Mar. 16, 2017), <https://www.nytimes.com/2017/03/16/us/joseph-nicolosi-dead-gay-conversion-therapist.html> [<https://perma.cc/JYT2-DE7C>] — which had “several limitations: its entire sample self-identified as religious and it is based on self-reports, which can be biased and unreliable”); Am. Psych. Ass’n, *supra* note 37, at 846 (“Research has primarily shown positive treatment outcomes when [transgender and gender nonconforming (TGNC)] adults and adolescents receive TGNC-affirmative medical and psychological services (i.e., psychotherapy, hormones, surgery).” (citation omitted)); CORDERO & CARLISLE, *supra* note 92, at 3 (citing study finding that queer teens who “reported higher levels of family rejection, including admission to conversion therapy, were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sex when compared to LGBTQ2-S peers that reported no or low levels of family rejection”); AM. PSYCH. ASS’N, *supra* note 100, at 2–3 (conducting systematic review of nearly fifty years of peer-reviewed journal literature on conversion practices and concluding that “there was some evidence to indicate that individuals experienced harm from [conversion practices],” specifically, “loss of sexual feeling, depression, suicidality, and anxiety,” and that “given the limited amount of methodologically sound research, claims that recent [conversion practices are] effective are not supported”); AM. PSYCH. ASS’N, REPORT OF THE APA TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE 27 (2008), <https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf> [<https://perma.cc/VE2F-YCGP>] (“Within the medicalized context, psychodynamic therapy for transvestism and transsexuality aimed to resolve underlying psychodynamic conflict, and behavioral therapy aimed to recondition behavior to reduce cross-gender behavior and increase comfort with the sex assigned at birth. By and large, these therapies failed.” (citations omitted)); POSITION STATEMENT ON THERAPIES FOCUSED ON ATTEMPTS TO CHANGE SEXUAL ORIENTATION (REPARATIVE OR CONVERSION THERAPIES), AM. PSYCHIATRIC ASS’N 2 (2000), http://media.mlive.com/news/detroit_impact/

outcomes of conversion practices,” with numerous scientific studies demonstrating that people who undergo conversion practices are at higher risk of attempting suicide and experiencing suicidal ideation and psychological distress (p. 82).¹²⁷ This is especially true for youth, who are often pressured by family members to undergo conversion therapy, and whose psychological distress is compounded when parents or siblings reject them because of their inability to change.¹²⁸

Numerous professional medical and mental health organizations in the United States, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Counseling Association, American Academy of Pediatrics, National Association of Social Workers, and American Mental Health Counselors Association, have rejected the use of conversion practices on grounds that such practices are harmful and unethical (pp. 83–84, 180–83).¹²⁹ A broad range of professional medical associations throughout the world have likewise condemned such practices, including the World Medical Association, the World Psychiatric Association, the Pan American Health Organization (a regional office of the World Health Organization), and national psychological associations in Brazil, Canada, Hong Kong, India, Lebanon, the Philippines, South Africa, Thailand, Turkey, and the United Kingdom (pp. 178–80).¹³⁰

The national and international medical community’s rejection of conversion practices finds support in the law. In 2015, the American Bar Association (ABA) adopted a resolution “urg[ing] all federal, state, local, territorial and tribal governments to enact laws that prohibit state-

other/APA_position_conversion%20therapy.pdf [https://perma.cc/EF3K-ZLUT] (“In the last four decades, ‘reparative’ therapists have not produced any rigorous scientific research to substantiate their claims of cure.”); *APA Resolution on Sexual Orientation Change Efforts*, AM. PSYCH. ASS’N (Feb. 2021), <https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf> [https://perma.cc/L7K7-R5SL] (“[R]esearch studies using a wide range of designs have found harms associated with [conversion practices], including . . . [s]uicidal behavior and depressive symptoms among youth and adults . . . [and] [m]ore mental health problems and lower levels of life satisfaction, social support, educational attainment, and socioeconomic status.” (citations omitted)). See generally NCLR & HRC REPORT, *supra* note 17, at 10–12 (discussing ineffectiveness and harm of conversion practices).

¹²⁷ Ashley cites studies finding that 62.6% of LGBTQ individuals who underwent conversion practices “seriously considered suicide, compared to 37.6 percent of those who had not undergone conversion practices,” and that transgender people who underwent conversion practices were “1.56 times more likely to have experienced severe psychological distress in the last month, 1.49 times more likely to have attempted suicide in the last year, and 2.27 times more likely to have attempted suicide in their lifetime” (p. 82).

¹²⁸ NCLR & HRC REPORT, *supra* note 17, at 11; see also ABA RESOLUTION, *supra* note 17, at 2, 4 (stating that “minors . . . are often forced or coerced into undergoing [conversion practices] by their parents or legal guardians,” and that “[f]amily conflict over a youth’s sexual orientation and gender identity places youth at high risk of serious, long-term negative impacts on their health and well-being”).

¹²⁹ See NCLR & HRC REPORT, *supra* note 17, at 11 (listing professional associations).

¹³⁰ See Ryan Thoreson, “Discriminalization”: *Sexuality, Human Rights, and the Carceral Turn in Antidiscrimination Law*, 110 CALIF. L. REV. 431, 456 (2022).

licensed professionals from using conversion therapy on minors.”¹³¹ According to the ABA, conversion practices “present significant risks of physical and mental harm,”¹³² particularly for LGBTQ youth;¹³³ are “ineffective, unsafe, and completely out-of-step with current scientific understanding of sexual orientation and gender identity”;¹³⁴ and violate the most basic equality of LGBT people — “the very right . . . to exist.”¹³⁵

Additionally, twenty-six states, the District of Columbia, and Puerto Rico have enacted legislation that partially or completely bans conversion practices,¹³⁶ and a number of cities and counties in states without statewide bans have enacted bans at the local level.¹³⁷ Outside of the United States, at least fourteen countries have partially or completely banned these practices.¹³⁸ As Ashley notes, while the bans differ in certain respects from state to state and from country to country,¹³⁹ they “share a similar recognition that trans conversion practices are psychopathologizing, transantagonistic, and have no place in the contemporary clinical apparatus” (p. 70).

At least four federal appeals court decisions likewise recognize the harmfulness of conversion practices. In 2014, in *Pickup v. Brown*,¹⁴⁰ the Ninth Circuit upheld a California law that prohibited licensed mental health practitioners from providing conversion practices to minors. According to the Ninth Circuit, the California legislature “relied on the well-documented, prevailing opinion of the medical and psychological community that [conversion therapy] has not been shown to be effective

¹³¹ ABA RESOLUTION, *supra* note 17 (adopting resolution).

¹³² *Id.* at 2.

¹³³ *Id.* at 4.

¹³⁴ *Id.* at 2.

¹³⁵ *Id.* at 11.

¹³⁶ *Conversion “Therapy” Laws*, MOVEMENT ADVANCEMENT PROJECT (Oct. 25, 2022), https://www.lgbtmap.org/equality-maps/conversion_therapy [<https://perma.cc/U4FM-ZJ6K>].

¹³⁷ *Id.* The reach of these local-level bans varies among states, protecting 39% of the population of Alaska, 26% of Pennsylvania, and 25% of Kentucky at the high end, and 3% of the population of South Carolina and Oklahoma at the low end. *Id.* The Eleventh Circuit has enjoined the enforcement of local bans in Alabama, Georgia, and Florida. *Id.*

¹³⁸ *Which Countries Have Already Banned Conversion Therapy?*, STONEWALL (Apr. 1, 2022), <https://www.stonewall.org.uk/about-us/news/which-countries-have-already-banned-conversion-therapy> [<https://perma.cc/2H4U-3D3R>].

¹³⁹ For example, some states — like Hawaii, Maine, Massachusetts, and Rhode Island — prohibit not only engaging in conversion practices but also advertising such practices (p. 58). Others, like Connecticut, classify conversion practices as unfair or deceptive trade practices subject to a private right of action, in addition to subjecting licensed professionals to disciplinary sanctions by licensing authorities (pp. 66–67).

¹⁴⁰ 740 F.3d 1208 (9th Cir. 2014).

and that it creates a potential risk of serious harm to those who experience it.”¹⁴¹

In 2014, in *King v. Governor of New Jersey*,¹⁴² the Third Circuit Court of Appeals likewise upheld New Jersey’s law banning conversion practices on minors based on “substantial evidence” that conversion therapy was “harmful” and “ineffective.”¹⁴³ According to the court:

It is not too far a leap in logic to conclude that a minor client might suffer psychological harm if repeatedly told by an authority figure that her sexual orientation — a fundamental aspect of her identity — is an undesirable condition. Further, if [conversion practices are] ineffective — which . . . is supported by substantial evidence — it would not be unreasonable for a legislative body to conclude that a minor would blame herself if her counselor’s efforts failed.¹⁴⁴

The court also concluded that New Jersey’s law was not “overly burdensome,” based on the “especially vulnerable” position of minors, who “may feel pressured to receive [conversion therapy] counseling by their families and their communities despite their fear of being harmed.”¹⁴⁵

In 2020, in *Grimm v. Gloucester County School Board*, a case ruling in favor of a transgender boy who was prohibited from using the boys’ restroom at his school, the Fourth Circuit observed that, “[f]or many years, mental health practitioners attempted to convert transgender people’s gender identity to conform with their sex assigned at birth, which did not alleviate dysphoria, but rather caused shame and psychological pain.”¹⁴⁶

And in 2022, in *Tingley v. Ferguson*,¹⁴⁷ the Ninth Circuit upheld a Washington ban on conversion practices that was nearly identical to California’s ban in *Pickup*. According to the Ninth Circuit, the Washington legislature acted rationally when, in reliance on a “‘scientifically credible proof of harm’ to minors from conversion therapy,”¹⁴⁸ it “decided to protect the ‘physical and psychological well-being’ of its

¹⁴¹ *Id.* at 1223; *see also* *Otto v. City of Boca Raton*, 981 F.3d 854, 877–78 (11th Cir. 2020) (Martin, J., dissenting) (citing “a mountain of rigorous evidence” that conversion practices “pose real risks of harm on children”); *Ferguson v. JONAH*, No. HUD-L-5473-12, 2015 WL 609436, at *10 (N.J. Super. Ct. Law Div. Feb. 5, 2015) (barring the admission of expert testimony advancing “the[] scientifically discredited belief that homosexuality is abnormal or a mental disorder” that can be resolved through sexual orientation conversion practices).

¹⁴² 767 F.3d 216 (3d Cir. 2014).

¹⁴³ *Id.* at 237–38.

¹⁴⁴ *Id.* at 239.

¹⁴⁵ *Id.* at 239–40.

¹⁴⁶ *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 595 (4th Cir. 2020); *accord* *Kadel v. N.C. State Health Plan for Tchrs. & State Emps.*, 12 F.4th 422, 427 (4th Cir. 2021) (“Just like being cisgender, being transgender is natural and is not a choice.” (quoting *Grimm*, 972 F.3d at 594)).

¹⁴⁷ 47 F.4th 1055 (9th Cir. 2022).

¹⁴⁸ *Id.* at 1078 (quoting *Pickup v. Brown*, 740 F.3d 1208, 1232 (9th Cir. 2014)).

minors by preventing state-licensed health care providers from practicing conversion therapy on them.”¹⁴⁹

Human rights organizations and faith leaders have likewise rejected conversion practices. The United Nations Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity, for example, has stated that conversion practices “are by their very nature degrading, inhuman and cruel and create a significant risk of torture” and has called on governments to ban them.¹⁵⁰ A growing number of religious leaders and organizations have also supported banning conversion practices, which they characterize as “misus[ing] faith-based values that rather should be used to welcome the stranger, love our neighbor as ourselves, and affirm the inherent worth and dignity of every person.”¹⁵¹

III. THE CONSTITUTIONALITY OF BANS ON CONVERSION PRACTICES

Proponents of conversion practices have fought legislative bans, claiming that the U.S. Constitution protects the practice. Ashley dedicates a substantial portion of their book to examining these baseless claims (pp. 71–102). Through a comparative analysis of Canadian and U.S. law, Ashley argues that laws banning conversion practices do not violate constitutional law — specifically, practitioners’ freedom of speech, parental autonomy and free exercise of religion, and the prohibition on vague or overbroad legislation (pp. 71–72). We agree with their assessment as to each, and we focus our comments on the free speech challenge.

As Ashley notes, three federal courts of appeals have considered free speech challenges to state laws prohibiting licensed mental health professionals from subjecting minors to conversion practices (p. 86). Two

¹⁴⁹ *Id.* (quoting *Pickup*, 740 F.3d at 1232); *see also id.* at 1089 (“[T]he law is targeted toward the scientifically documented increased risk of suicide and depression from having a licensed mental health provider try to change you.”).

¹⁵⁰ Victor Madrigal-Borloz (Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity), *Practices of So-Called “Conversion Therapy,”* ¶¶ 83, 87, U.N. Doc. A/HRC/44/53 (May 1, 2020); *see id.* ¶ 14.

¹⁵¹ Letter from Faith Leaders in Support of Bans on Conversion “Therapy” (Sept. 2014), <https://www.nclrights.org/wp-content/uploads/2014/09/Conversion-Therapy-Faith-Leader-Letter.pdf> [<https://perma.cc/K4CK-4FH2>]; *see also* GLOB. INTERFAITH COMM’N ON LGBT+ LIVES, <https://globalinterfaith.lgbt> [<https://perma.cc/E9QN-8VNM>] (“recognis[ing] that certain religious teachings have, throughout the ages, been misused to cause deep pain and offense to those who are lesbian, gay, bisexual, transgender, queer and intersex,” and calling for a global ban on conversion practices). *See generally* NCLR & HRC REPORT, *supra* note 17, at 46–47 (listing LGBT-affirming religious organizations).

courts of appeals have upheld these laws against such challenges; one court has enjoined such laws as violative of free speech.¹⁵²

The First Amendment prohibits laws that abridge the freedom of speech.¹⁵³ Content-based regulations of speech receive strict scrutiny, while content-neutral regulations of speech receive intermediate scrutiny.¹⁵⁴ Importantly, “[s]tates may regulate professional conduct, even though that conduct incidentally involves speech.”¹⁵⁵ In *Pickup*, the Ninth Circuit rejected the claim that a California law prohibiting conversion practices violated conversion practitioners’ free speech rights.¹⁵⁶ Because the law applied to *conduct* — to the practice of a form of medical treatment on minors involving aversive techniques and talk therapy — and only incidentally affected speech, it did not run afoul of the First Amendment.¹⁵⁷ Indeed, “[m]ost, if not all, medical and mental health treatments require speech, but that fact does not give rise to a First Amendment claim when the state bans a particular treatment. . . . Were it otherwise, then any prohibition of a particular medical treatment would raise First Amendment concerns because of its incidental effect on speech.”¹⁵⁸ Talk therapy, in particular, would be immune from regulation.¹⁵⁹

Importantly, California’s law did not prevent licensed therapists from discussing with their patients the pros and cons of conversion practices or gender-transition care.¹⁶⁰ What it banned was *conduct* — the practice of a form of treatment on minors.¹⁶¹ As a plurality of the Supreme Court concluded in *Planned Parenthood of Southeastern*

¹⁵² See *infra* pp. 1136–39 (discussing *Pickup*, 740 F.3d at 1208; *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014); *Otto v. City of Boca Raton*, 981 F.3d 854 (11th Cir. 2020); *Tingley*, 47 F.4th at 1055).

¹⁵³ U.S. CONST. amend. I.

¹⁵⁴ See *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 213 (1997).

¹⁵⁵ *Nat’l Inst. of Fam. & Life Advoc. v. Becerra*, 138 S. Ct. 2361, 2372 (2018); see also *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (joint opinion of O’Connor, Kennedy & Souter, JJ.) (finding “no constitutional infirmity in the requirement that the physician provide [information to patients about certain risks of abortion] mandated by the State” because such a requirement regulates speech only “as part of the practice of medicine, subject to reasonable licensing and regulation by the State”), *overruled on other grounds* by *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

¹⁵⁶ *Pickup*, 740 F.3d at 1232.

¹⁵⁷ See *id.* at 1229–31 (“[A] regulation of only *treatment itself* — whether physical medicine or mental health treatment — implicates free speech interests only incidentally, if at all.” *Id.* at 1231).

¹⁵⁸ *Id.* at 1229.

¹⁵⁹ See *id.* at 1231 (“[T]alk therapy [is] ‘the *treatment* of emotional suffering and depression, *not* speech.” (quoting *Nat’l Ass’n for the Advancement of Psychoanalysis v. Cal. Bd. of Psych.*, 228 F.3d 1043, 1054 (9th Cir. 2000))); see also *Tingley v. Ferguson*, 47 F.4th 1055, 1082 (9th Cir. 2022) (stating that if Washington’s ban on conversion practices were “an unconstitutional content-based restriction on the speech of licensed health care professionals, then this would preclude other reasonable ‘health and welfare laws’ that apply to health care professionals and impact their speech,” including “centuries-old medical malpractice laws that restrict treatment and the speech of health care providers” (quoting *Dobbs*, 142 S. Ct. at 2284)).

¹⁶⁰ See *Pickup*, 740 F.3d at 1229.

¹⁶¹ *Id.*

Pennsylvania v. Casey,¹⁶² there is “no constitutional infirmity” in a state’s mandating that a physician provide information to patients about certain risks of a medical procedure because such a requirement regulates speech only incidentally “as part of the *practice* of medicine, [which is] subject to reasonable licensing and regulation by the State.”¹⁶³ Applying rational basis review, the *Pickup* court upheld the California law as rationally related to the state’s legitimate interest in protecting minors from harm.¹⁶⁴

In *King*, the Third Circuit took a different tack in upholding New Jersey’s conversion-practices ban against a free speech challenge.¹⁶⁵ Rather than concluding that the law was subject to rational basis review because it regulated conduct and only incidentally affected speech, as the Ninth Circuit did in *Pickup*, the Third Circuit in *King* held that the law regulated speech, but only “professional speech,” and was therefore subject to intermediate scrutiny.¹⁶⁶ According to the court in *King*, “a licensed professional does not enjoy the full protection of the First Amendment when speaking as part of the practice of her profession.”¹⁶⁷ “To handcuff the State’s ability to regulate a profession whenever speech is involved” through the application of strict scrutiny, the Third Circuit reasoned, would “unduly undermine its authority to protect its citizens from harm.”¹⁶⁸ Applying intermediate scrutiny, the *King* court held that the law “‘directly advance[d]’ New Jersey’s stated interest in protecting minor citizens from harmful professional practices” and was not “more extensive than necessary to protect this interest.”¹⁶⁹

Contrary to *Pickup* and *King*, the Eleventh Circuit, in *Otto v. City of Boca Raton*,¹⁷⁰ struck down two cities’ bans on conversion practices on grounds that they violated the free speech rights of conversion practitioners.¹⁷¹ While acknowledging that “[s]tates may regulate professional conduct, even though that conduct incidentally involves speech,”¹⁷² the *Otto* court rejected the reasoning of the Ninth Circuit in *Pickup* and concluded that the bans on conversion practices directly regulated speech, not conduct, because such practices “consist[] — entirely — of words.”¹⁷³ If such practices were considered conduct, the court stated, “the same could be said of teaching or

¹⁶² 505 U.S. 833 (1992).

¹⁶³ *Pickup*, 740 F.3d at 1228 (emphasis added) (quoting *Casey*, 505 U.S. at 884 (joint opinion of O’Connor, Kennedy & Souter, JJ.)).

¹⁶⁴ *See id.* at 1232.

¹⁶⁵ *See King v. Governor of New Jersey*, 767 F.3d 216, 240 (3d Cir. 2014).

¹⁶⁶ *Id.* at 235–36; *see also id.* at 224.

¹⁶⁷ *Id.* at 232.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 239.

¹⁷⁰ 981 F.3d 854 (11th Cir. 2020).

¹⁷¹ *Id.* at 868–70.

¹⁷² *Id.* at 865 (quoting *Nat’l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2372 (2018)).

¹⁷³ *Id.*

protesting[,] . . . [d]ebating[,] . . . [and b]ook clubs.”¹⁷⁴ Relying on the Supreme Court’s statement in *National Institute of Family and Life Advocates v. Becerra*¹⁷⁵ that “professional speech” is not a separate category of speech entitled to diminished constitutional protection, the *Otto* court also rejected the Third Circuit’s application of intermediate scrutiny in *King*.¹⁷⁶ Applying strict scrutiny, the *Otto* court held that the cities had failed to show that their bans were narrowly tailored to further a compelling interest.¹⁷⁷

In dissent, Judge Martin declined to answer the “difficult question” whether the ordinances regulated speech or conduct that incidentally involved speech.¹⁷⁸ Citing a “mountain of rigorous evidence”¹⁷⁹ that conversion practices “pose real risks of harm on children,”¹⁸⁰ Judge Martin concluded that, even if the bans were content-based speech restrictions, they withstood strict scrutiny because they were “the least restrictive means”¹⁸¹ of achieving “a compelling government interest in protecting minors from a harmful medical practice.”¹⁸²

Nearly a decade after rejecting a free speech challenge to California’s conversion-practices ban in *Pickup*, the Ninth Circuit reaffirmed *Pickup*’s reasoning in *Tingley*, which involved a free speech challenge to a nearly identical Washington law.¹⁸³ According to the court in *Tingley*, the Washington law regulated “professional conduct that incidentally involve[d] speech” and, therefore, rational basis review applied.¹⁸⁴ The court upheld the Washington law as rationally related to preventing conversion practices’ harm to minors¹⁸⁵ — adding that “[s]tates do not lose the power to regulate the safety of medical treatments performed under the authority of a state license merely because those treatments are implemented through speech rather than through scalpel.”¹⁸⁶

We agree with Ashley that *Pickup* (and its progeny, *Tingley*) provides the most persuasive free speech analysis of bans on conversion practices. “Conversion practices,” they state:

¹⁷⁴ *Id.*

¹⁷⁵ 138 S. Ct. 2361.

¹⁷⁶ See *Otto*, 981 F.3d at 867 (quoting *Nat’l Inst. of Fam. & Life Advoc.*, 138 S. Ct. at 2371–72).

¹⁷⁷ See *id.* at 868–70.

¹⁷⁸ *Id.* at 873 (Martin, J., dissenting).

¹⁷⁹ *Id.* at 878.

¹⁸⁰ *Id.* at 877.

¹⁸¹ *Id.* at 879.

¹⁸² *Id.* at 875.

¹⁸³ See *Tingley v. Ferguson*, 47 F.4th 1055, 1077 (9th Cir. 2022).

¹⁸⁴ *Id.* at 1077–80.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 1064. As further support for their decision, two judges in *Tingley* provided an alternative reason for applying rational basis review to Washington’s ban on conversion practices: “[A] long (if heretofore unrecognized) tradition of regulation governing the practice of those who provide health care within state borders.” *Id.* at 1080.

are best understood as conduct rather than speech . . . [because they] are not inherently expressive; they do not fundamentally seek to communicate a point of view. . . . Even when conducted solely through talk therapy, conversion practices deploy psychological methods in a systematic manner that is deliberately tailored to effect a psychological change in the subject. (p. 74)¹⁸⁷

Unlike teaching, protesting, debating, and discussing books, conversion practices do not seek to enlighten or persuade; they seek to treat patients through the practice of medicine.¹⁸⁸ *Casey*'s holding that informed consent laws do not violate free speech rights, which the *Otto* court remarkably did not cite, strongly supports this conclusion.¹⁸⁹ Although effectuated through speech, informed consent, like conversion practices, is conduct; it is "part of the *practice* of medicine."¹⁹⁰ Such conduct is therefore "subject to reasonable licensing and regulation by the State," notwithstanding the fact that such "conduct incidentally involves speech."¹⁹¹ Alternatively, even if intermediate or strict scrutiny applies, bans on conversion therapy survive review because they are narrowly tailored to protect young people from harmful professional practices, as discussed by the Third Circuit in *King* and Judge Martin's dissent in *Otto*.¹⁹²

We agree with Ashley that other constitutional challenges fare no better. Bans on conversion practices do not infringe on parents' fundamental right under the Fourteenth Amendment to make decisions regarding their children.¹⁹³ No one — let alone parents on behalf of their

¹⁸⁷ See *Pickup v. Brown*, 740 F.3d 1208, 1229–31 (9th Cir. 2014); cf. *King v. Christie*, 981 F. Supp. 2d 296, 317 (D.N.J. 2013) ("[C]ounseling is more properly understood as a method of treatment, not speech, since the core characteristic of counseling is not that it may be carried out through talking, but rather that the counselor applies methods and procedures in a therapeutic manner.").

¹⁸⁸ See *Pickup*, 740 F.3d at 1226 ("[T]he key component of psychoanalysis is the treatment of emotional suffering and depression, *not* speech." (alteration in original) (quoting Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psych., 228 F.3d 1043, 1054 (9th Cir. 2000))); see also *Tingley*, 47 F.4th at 1082–83 ("What licensed mental health providers do during their appointments with patients for compensation under the authority of a state license is *treatment* Comparing the work that licensed mental health providers do to book club discussions or conversations among friends minimizes the rigorous training, certification, and post-secondary education that licensed mental health providers endure to be able to treat other humans for compensation." (emphasis added)). Teaching, moreover, is a doubly flawed analogy because it *is* constitutionally regulated. Recent Case, *Otto v. City of Boca Raton*, 981 F.3d 854 (11th Cir. 2020), 134 HARV. L. REV. 2863, 2869 (2021) ("Teaching — speech inside of the classroom that is itself part of the practice of educating students — is not entitled to full First Amendment protection.").

¹⁸⁹ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.).

¹⁹⁰ *Id.* (emphasis added); see also Recent Case, *supra* note 188, at 2867 ("[S]peech that is itself a 'part of the *practice* of medicine' constitute[s] speech incidental to conduct and, therefore, [i]s unprotected by the First Amendment." (quoting Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361, 2373 (2018))).

¹⁹¹ *Nat'l Inst. of Fam. & Life Advocs.*, 138 S. Ct. at 2372–73 (quoting *Casey*, 505 U.S. at 884 (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

¹⁹² See *supra* pp. 1137–38.

¹⁹³ See *Pickup*, 740 F.3d at 1236.

children — has a constitutional right to demand harmful, unethical interventions.¹⁹⁴ Bans on conversion practices also do not violate the First Amendment right to the free exercise of religion because they are “neutral” and “generally applicable”; they target all conversion practices, religious and secular.¹⁹⁵ Additionally, bans are neither vague nor overbroad. Mental health practitioners, including the very practitioners who have challenged bans in court, understand what practices qualify as conversion practices.¹⁹⁶ Bans on conversion likewise do not “go beyond their plainly legitimate sweep”;¹⁹⁷ they do not, for example, “prohibit[] speech *wholly apart* from the actual provision of treatment,” such as discussion of the pros and cons of conversion practices and gender-transition care¹⁹⁸ or other speech that does not, in Ashley’s words,

¹⁹⁴ Compare *id.* (rejecting parents’ claim that conversion-practices ban violated their fundamental right to make decisions about the care of their children because “the fundamental rights of parents do not include the right to choose a specific type of provider for a specific medical or mental health treatment that the state has reasonably deemed harmful”), with *Eknes-Tucker v. Marshall*, No. 22-cv-184, 2022 WL 1521889, at *8 (M.D. Ala. May 13, 2022) (holding that parents were likely to succeed on claim that Alabama’s criminalization of gender-transition care violated their fundamental right to make decisions about the care of their children because, *inter alia*, “the uncontradicted record evidence is that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors”). Ashley states that governments’ power to regulate or ban medically “unproven, ineffective, risky, and harmful treatment is well established”; were it not, agencies like the U.S. Food and Drug Administration would cease to exist in their current form (p. 97).

¹⁹⁵ See *King v. Governor of New Jersey*, 767 F.3d 216, 241–43 (3d Cir. 2014) (holding that ban on conversion practices did not violate First Amendment right to free exercise of religion); *accord Tingley v. Ferguson*, 47 F.4th 1055, 1087–89 (9th Cir. 2022) (holding that Washington law that “prohibits, or more accurately deems ‘unprofessional,’ the practice of conversion therapy by all licensed providers (regardless of their religious or secular motivations) on clients who are under the age of 18 (regardless of their religious or secular motivations),” *id.* at 1087, is “neutral and generally applicable, and survives rational basis review,” *id.* at 1089). According to the Third and Ninth Circuits, the fact that conversion-practice bans *permit* gender-transition care does not suggest that the ban “covertly targets . . . religion by prohibiting counseling that is generally religious in nature while permitting other forms of counseling that are equally harmful to minors”; rather, it reflects the medical consensus that gender-transition care is not harmful to minors. *King*, 767 F.3d at 242; see also *Tingley*, 47 F.4th at 1088–89 (rejecting conversion practitioner’s “contention that gender-affirming therapy ‘can lead to the very types of psychological harms’ Washington says it wants to eliminate by prohibiting conversion therapy”). Ashley states: “Conversion practices are not targeted out of religious animus . . . but, rather, because they are harmful If freedom of religion could so readily defeat legislative endeavors, then nearly every law would need religious exceptions — few behaviours cannot be depicted as a consequence of religious commitment” (p. 95).

¹⁹⁶ See *King*, 767 F.3d at 240–41 (rejecting vagueness claim and concluding that “[t]o those in the field of professional counseling, the meaning of [sexual orientation change efforts] . . . is sufficiently definite ‘in the vast majority of its intended applications,’” *id.* at 241 (citation omitted)); *Pickup*, 740 F.3d at 1234 (rejecting vagueness claim and concluding that “[a] reasonable person would understand the statute to regulate only mental health treatment, including psychotherapy, that aims to alter a minor patient’s sexual orientation”); *accord Tingley*, 47 F.4th at 1091 (“[T]he law ‘provides both sufficient notice as to what is prohibited and sufficient guidance to prevent against arbitrary enforcement.’” (quoting *United States v. Kuzma*, 967 F.3d 959, 970 (9th Cir. 2020))).

¹⁹⁷ *Pickup*, 740 F.3d at 1235.

¹⁹⁸ *Id.* at 1229 (rejecting overbreadth claim); see also *King*, 767 F.3d at 241 (same).

“attempt[] to change someone’s psyche through the structured application of psychological techniques” (p. 77).

Although not mentioned specifically in Ashley’s book, bans on conversion practices also do not violate the freedom of association under the First Amendment.¹⁹⁹ The relationship between counselors and clients does not “implicate the fundamental rights associated with . . . close-knit relationships,” such as “personal decisions about marriage, childbirth, raising children, cohabiting with relatives, and the like,” and is therefore not the type of “intimate human relationship[]” protected by the First Amendment.²⁰⁰

IV. MODEL BANS AND BEYOND

Ashley dedicates the last chapter of their book to proposing a model law, drawn from various jurisdictions throughout the world, that broadly prohibits conversion practices (pp. 130–73). The model law protects people of all ages, applies to all private individuals — not just medical providers — and defines conversion practices expansively to include any “sustained efforts” that: aim to discourage any behavior associated with a gender other than the person’s assigned sex at birth; seek to identify the factors that may have caused the person’s sexual orientation or gender identity; direct parents to set limits on children’s gender-nonconforming behavior or impose interaction with peers of the same sex assigned at birth; or delay or impede a person’s social or medical transition (p. 135). Additionally, the model law prohibits a wide range of conduct beyond offering and advertising conversion practices, including insurance coverage for conversion practices and preferential tax status for entities that facilitate engaging in conversion practices (p. 139). The model law also provides various means of enforcement, including not only a private right of action for monetary damages and injunctive relief and discipline by licensing boards, but also dissolution of a corporation engaged in conversion practices (p. 139).

By gathering, in detail and all in one place, a range of policy options for legislators across the world to consult, Ashley’s model law is an important step forward toward ending conversion practices. We offer three observations related to Ashley’s model law and to law reform more generally, with particular attention paid to the undertheorized “troubled teen industry.”

¹⁹⁹ See *Pickup*, 740 F.3d at 1232 (rejecting claim that conversion-practices ban violated the freedom of association).

²⁰⁰ *Id.* at 1233 (quoting *Roberts v. U.S. Jaycees*, 468 U.S. 609, 617–19 (1984); *Nat’l Ass’n for the Advancement of Psychoanalysis v. Cal. Bd. of Psych.*, 228 F.3d 1043, 1054 (9th Cir. 2000)).

A. *Starting Point*

As with all model legislation, advocates should not feel constrained by the model law's precise terms. A law that takes a different approach to banning conversion practices, or that effectuates only some of the model law's provisions, should not be construed by advocates as inferior. "The model is best viewed as a starting point," Ashley notes, with legislators and policymakers adapting the model to account for practical limitations and local concerns (p. 134).

In our view, Ashley's proposed model, despite its merits, may not be the right starting point for legislative action because of the breadth of policy change it seeks to effectuate — expansively regulating private conduct well outside of professional relationships. In the United States, for example, many provisions in Ashley's model law are unlikely to pass constitutional muster. Ashley's model is breathtakingly broad. In contrast to the conversion-practices bans passed in the United States focused principally on regulating licensed providers, Ashley's proposal subjects to civil liability any private individual who, for example, continually urges someone to change their sexual orientation or gender identity or who even knowingly refers someone to a professional for that purpose.²⁰¹ While such broad coverage might make sensible policy, it is legally problematic, at least in the United States. As Ashley herself acknowledges, this breadth potentially runs afoul of numerous constitutional guarantees, including free speech, associational rights, religious liberties, and perhaps even constitutional privacy guarantees (p. 69).²⁰²

In addition to its constitutional infirmities, Ashley's model law contains several provisions that threaten to undermine the important policy outcomes that they seek. For example, Ashley defines "conversion practices" to include efforts that are "without adequate justification," "without reasonable and non-judgmental clinical justification," or not carried out "in the context of research that has been approved by an institutional review board" (p. 135). These provisions invite disingenuous, counterfactual narratives by proponents of conversion practices as to the adequacy and reasonableness of their justifications and the authoritativeness of their research. The model law also invites searching, legally irrelevant inquiries into practitioners' motivations (for example, by banning practices that "proceed from the assumption that" certain gender

²⁰¹ Compare pp. 134–35 (defining "conversion practices" to include, inter alia, "any . . . sustained effort . . . to change, discourage, or repress a person's sexual orientation [or] gender identity"), with pp. 138–39 (stating that "[a]nyone who engages in conversion practices or knowingly refers an individual to someone who engages in conversion practices" has violated the law and that any person harmed by conversion practices "may bring a private action against the perpetrator" (emphasis added)).

²⁰² Ashley states that "[b]ans may have more difficulty passing constitutional muster if they target people who are not licensed professionals since they come closer to impinging upon private relations" (p. 69). See also *supra* Part III, pp. 1135–41 (discussing challenges to bans on conversion practices).

identities are pathological or that transition is undesirable) and survivors' lives (for example, by banning practices that intervene in a person's "naturalistic environment" with the aim of changing the person's gender identity) (p. 135).

In the United States, existing state laws provide the best models for banning conversion practices. As further discussed below, state bans are limited: they exclusively protect minors, focus primarily on licensed medical and mental health providers, and do not reach unlicensed religious advisors.²⁰³ Although narrower in scope and impact than Ashley's model law, these state laws track well-established legal structures related to licensed professionals and those engaged in trade or commerce. Accordingly, state legislative bans modeled on existing state laws are more likely to withstand legal challenge and less likely to provoke backlash.

B. The Lifesaving Impact, and Limits, of Bans on Conversion Practices

Passage of conversion-practices bans has an important practical effect: it saves transgender lives. Opponents of transgender rights, and some in the transgender and allied advocacy communities, have characterized bans on conversion practices as largely or purely symbolic (pp. 105–07).²⁰⁴ Some argue that conversion practices no longer take place.²⁰⁵ Others argue that, even if such practices do take place, bans do not prevent these practices because the bans apply only to *licensed* professionals, who purportedly do not engage in these practices.²⁰⁶ Still others suggest that law is the wrong tool for preventing these practices; resources should instead be directed toward grassroots social advocacy aimed at undermining gender normativity and the regulation of

²⁰³ See *infra* section IV.B, pp. 1143–46 (discussing the limitations of bans on conversion therapy).

²⁰⁴ Ashley discusses the argument that bans on conversion practices may be “primarily expressive” and “fail to address the lived conditions of trans people” (p. 106).

²⁰⁵ See Leslie Wolfgang, *Dear LGBT Lobby: Name Them*, FAM. INST. OF CONN. (Mar. 7, 2017), <http://www.ctfamily.org/4203-2> [<https://perma.cc/U8Z5-NBQ6>] (stating that bans on conversion practices are “a solution in search of a problem,” and challenging proponents of Connecticut’s bill banning conversion practices to “name the licensed professionals in Connecticut that supposedly practice conversion therapy . . . [because we] don’t believe their claims that this exists in Connecticut”).

²⁰⁶ See *id.*; see also Marie-Amélie George, *Expressive Ends: Understanding Conversion Therapy Bans*, 68 ALA. L. REV. 793, 799 (2017) (discussing criticism of bans on conversion practices as “not reach[ing] the majority of practitioners” — namely, religious and lay counselors — and “therefore hav[ing] little practical effect”).

transgender bodies (pp. 103, 107).²⁰⁷ We, like Ashley, disagree with these arguments (p. 106).²⁰⁸

As explained above, conversion practices still endure: the Williams Institute estimates that nearly 75,000 current LGBTQ youth will undergo conversion practices before they reach the age of eighteen,²⁰⁹ and others estimate this number to be much higher.²¹⁰ Furthermore, conversion practices are not the exclusive province of unlicensed therapists and religious advisors; licensed practitioners engage in these practices as well. Prior to the passage of Connecticut's ban on conversion practices, for example, a licensed psychologist in Connecticut claimed on his website that "[s]ame-sex attraction (SSA) appears to be a condition that results from various psychological wounds and issues that develop during childhood," that "[t]he psychosocial development of an individual who manifests same-sex attractions is often fraught with pain and anguish," and that he could treat "men and women with unwanted same-sex attraction seeking to diminish same-sex feelings and behaviors and/or congruency between their sexuality and faith-based beliefs."²¹¹ Another licensed psychologist in Connecticut stated on his website that "homosexual acts are intrinsically disordered," and that individuals with "[h]omosexual tendencies . . . should be supported in their efforts to exercise self-mastery and live their lives chastely."²¹² And organizations like the National Association for Research and Therapy of Homosexuality (NARTH, now the NARTH Institute and part of the Alliance for Therapeutic Choice and Scientific Integrity),²¹³ continue to promote

²⁰⁷ Ashley discusses criticism of bans on conversion practices as unduly focused on establishing "[f]ormal protections and legal prohibitions" (p. 103), rather than resisting gender norms that stigmatize transgender people.

²⁰⁸ Ashley states that it is not accurate to describe conversion-practices bans as "primarily expressive" (p. 106).

²⁰⁹ MALLORY ET AL., *supra* note 11, at 1.

²¹⁰ See Forsythe et al., *supra* note 20, at 493 (estimating that, in 2021, 508,892 LGBTQ youth in the United States were at risk of being subjected to conversion therapy); see also MARK POTOK, S. POVERTY L. CTR., QUACKS: "CONVERSION THERAPISTS," THE ANTI-LGBT RIGHT, AND THE DEMONIZATION OF HOMOSEXUALITY 38 (2016), https://www.splcenter.org/sites/default/files/splc_report_on_conversion_therapy_small_o.pdf [<https://perma.cc/MDY8-5VZ4>] (discussing "10 of the most prominent ex-gay groups," while noting that "[t]here are many other smaller, similar groups, as well as uncounted individual practitioners").

²¹¹ *Clinic Testimony*, *supra* note 85, at 2–3.

²¹² *Id.* at 3.

²¹³ POTOK, *supra* note 210, at 42 (discussing NARTH and the Alliance for Therapeutic Choice and Scientific Integrity). NARTH was cofounded by now-deceased Dr. Joseph Nicolosi, an outspoken proponent of conversion practices. Ryan Lenz, *Joseph Nicolosi, Father of "Ex-gay Therapy," Dies from Flu Complications*, S. POVERTY L. CTR. (Mar. 10, 2017), <https://www.splcenter.org/hatewatch/2017/03/10/joseph-nicolosi-father-ex-gay-therapy-dies-flu-complications> [<https://perma.cc/NP93-EA6J>].

conversion practices among licensed mental health professionals and their patients.²¹⁴

Lastly, the argument that grassroots advocacy is better suited than law to root out conversion practices suggests an all-or-nothing, binary conception of social advocacy that is neither accurate nor helpful. Law reform and social advocacy are interactive, and both are important to accomplishing any social justice goal.²¹⁵ Legislative bans on conversion practices — together with agency action and private litigation to enforce such bans — have prevented harm to thousands of transgender people, but they have by no means eradicated these practices (p. 118). Indeed, no state prohibits religious advisors from engaging in conversion practices, and no state prohibits conversion practices on adults (pp. 58, 112–13).²¹⁶ Only twenty-six states (and the District of Columbia and Puerto Rico) prohibit conversion practices on youth, and only one of those states, Connecticut, extends this prohibition to unlicensed practitioners (p. 68).²¹⁷ Furthermore, a federal bill that would ban conversion practices nationwide remains stalled.²¹⁸

Bans are an important tool for eliminating conversion practices, but they are only one tool. As Ashley notes, “[u]ltimately, only a thorough change in culture will ensure the extinction of these harmful and degrading practices” (p. 176). Critical to the necessary cultural shift,

²¹⁴ See *Answers to Frequently Asked Questions About the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) and Homosexuality*, ALL. FOR THERAPEUTIC CHOICE & SCI. INTEGRITY, <https://www.therapeuticchoice.com/frequently-asked-questions> [<https://perma.cc/WG3R-YNWC>] (“focus[ing] on the right of persons to deal with unwanted sexual behavior and attractions as well as the right of therapists to offer psychological care to those who wish to deal with these concerns by managing, diminishing or eliminating them rather than just identifying with and acting upon them”); *Clinical Division*, ALL. FOR THERAPEUTIC CHOICE & SCI. INTEGRITY, <https://www.therapeuticchoice.com/clinical-division> [<https://perma.cc/gLRK-MG2E>] (providing training to licensed professionals); *Finding a Referral Therapist in the United States*, ALL. FOR THERAPEUTIC CHOICE & SCI. INTEGRITY, <https://www.therapeuticchoice.com/find-a-referral-therapist> [<https://perma.cc/7ARY-DA3L>] (providing referrals to licensed, professional therapists in United States).

²¹⁵ See, e.g., Stephen Loffredo, *Poverty Law and Community Activism: Notes from a Law School Clinic*, 150 U. PA. L. REV. 173, 176–77 (2001) (discussing “relationship between law reform and social activism,” *id.* at 177, in achieving social justice goals); see also Chai Feldblum, *Law, Policies in Practice and Social Norms: Coverage of Transgender Discrimination Under Sex Discrimination Law*, 14 J.L. SOC’Y 1, 27 (2013) (discussing relationship between litigation and the feminist movement’s “push[] for changes in societal expectations and practices” that led to achievement of social justice goal of prohibiting the use of gender in employment decisions); Julie A. Su, *Making the Invisible Visible: The Garment Industry’s Dirty Laundry*, 1 J. GENDER, RACE & JUST. 405, 408 (1998) (distinguishing between “social activism” and “traditional legal avenues” in achieving social change).

²¹⁶ See CHRISTY MALLORY ET AL., WILLIAMS INST., *CONVERSION THERAPY AND LGBT YOUTH* 3 (2018), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Jan-2018.pdf> [<https://perma.cc/35HL-SADD>] (noting that state bans on conversion practices “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”).

²¹⁷ See *Conversion “Therapy” Laws*, *supra* note 24.

²¹⁸ Therapeutic Fraud Prevention Act of 2021, S. 2242, 117th Cong.

Ashley argues, are “[g]rassroots, community-driven movements and pressures by healthcare professionals and organizations” (p. 118). These nonlegal, social advocacy efforts have been used successfully against licensed mental health professionals who engage in conversion practices, culminating in the closure of CAMH’s gender identity clinic in 2015 (pp. 3, 103). These efforts have also been leveraged against religious practitioners, contributing to the 2013 closure of Exodus International, a Christian ministry and the world’s largest provider of conversion practices, which issued a formal apology to members of the LGBTQ community and their families.²¹⁹ Notwithstanding these successes, conversion practices remain, and law reform and social advocacy, together, will both be needed to one day end them.

C. *The Troubled Teen Industry*

One understudied area that has begun to receive more attention from policymakers and social advocates, and that implicates conversion practices, is the so-called “troubled teen industry.”²²⁰ This industry, which consists of “a network of private youth programs, therapeutic boarding schools, residential treatment centers, religious academies, wilderness programs, and drug rehabilitation centers,” is “big business”: it is estimated that over 120,000 youth reside in troubled teen facilities nationwide, and, according to some reports, the industry annually receives billions of dollars in public funds alone.²²¹ Some youths are privately placed in troubled teen facilities by their parents or families.²²² Others are taken from the foster care and juvenile justice systems and placed in these facilities by state and local officials.²²³ Still others are placed in these facilities by school districts pursuant to an individualized

²¹⁹ NCLR & HRC REPORT, *supra* note 17, at 14; Scott Neuman, *Gay-Therapy Ministry Shuts Down, Says “We’ve Hurt People,”* NPR (June 20, 2013, 5:20 PM), <https://www.npr.org/sections/thetwo-way/2013/06/20/193922536/gay-therapy-ministry-shuts-down-says-weve-hurt-people> [<https://perma.cc/DJG7-RY6E>].

²²⁰ See, e.g., Amanda Robert, *Troubling Treatment: Efforts Are Underway to Reform Teen Behavioral Programs*, 107 ABA J. 46, 49 (2021); *The “Troubled Teen” Industry*, NAT’L YOUTH RTS. ASS’N, <https://www.youthrights.org/issues/medical-autonomy/the-troubled-teen-industry> [<https://perma.cc/F5UQ-VJ4B>]; Deirdre Sugiuchi, “*Conversion Therapy*” Is Abuse, DAME MAG. (Dec. 17, 2020), <https://www.damemagazine.com/2020/12/17/conversion-therapy-is-abuse> [<https://perma.cc/UXB6-TTW9>]; Ariel Sobel, *California Christian School Alleged to Be Conversion Therapy Nightmare*, ADVOCATE (Sept. 12, 2018, 5:40 PM), <https://www.advocate.com/youth/2018/9/12/california-christian-school-alleged-be-conversion-therapy-nightmare> [<https://perma.cc/55G9-7F64>].

²²¹ Cathy Krebs, *Five Facts About the Troubled Teen Industry*, AM. BAR ASS’N (Oct. 22, 2021), <https://www.americanbar.org/groups/litigation/committees/childrens-rights/practice/2021/5-facts-about-the-troubled-teen-industry> [<https://perma.cc/2F7R-CVXX>] (estimating that troubled teen industry annually receives \$23 billion in public funds); Alexander Stockton, Opinion, *Can You Punish a Child’s Mental Health Problems Away?*, N.Y. TIMES, <https://www.nytimes.com/interactive/2022/10/11/opinion/teen-mental-health-care.html> [<https://perma.cc/VU2U-R8E6>] (estimating that troubled teen industry annually receives “hundreds of millions in public funds”); see Robert, *supra* note 220, at 49.

²²² Krebs, *supra* note 221.

²²³ *Id.*

education program, by refugee settlement agencies, or by mental health providers.²²⁴

Troubled teen facilities promise to help youth with addiction, behavioral, and emotional problems.²²⁵ In many cases, these facilities also engage in conversion practices.²²⁶ Consider, for example, L.L.’s story.

L.L.’s family was struggling — her younger sister had cancer, her parents were considering divorce, and “there were financial pressures.”²²⁷ When she was around fourteen, L.L. came out to her parents as transgender.²²⁸ “My parents were not accepting and told me that as long as I was under their roof, they would not accept me,” she recalled.²²⁹ As things became more unstable at home, L.L. “felt unsafe and ran away.”²³⁰ Her parents turned to the troubled teen industry.²³¹ One day, two men hired by her parents apprehended her and took her to Elevations (formerly Island View), a residential facility in Utah.²³² She was initially told that she would be there no longer than one to three months — she ended up remaining at Elevations for one and a half years, plus another six months at a step-down program operated by the same company that owned Elevations.²³³

In sworn testimony, L.L. detailed her experiences at Elevations. She explained that, on the day she arrived, staff took from her clothing and personal belongings considered “gender-inappropriate.”²³⁴ According to L.L., male staff strip-searched her and, when she resisted, they pinned her to the floor and placed her in isolation for an entire day.²³⁵ L.L. said that, to “work out [her] issues,” staff placed her in the boys’ dormitory and prohibited her from looking at or speaking to “anyone in the female dorm for fear that they would validate [L.L.’s female] identity, which many of the girls did.”²³⁶ L.L. testified that staff referred to her exclusively by a male name and with male pronouns, and they punished anyone, including other youth and L.L. herself, for referring to L.L. by her chosen name.²³⁷

According to L.L., Elevations supported L.L.’s parents’ rejection of her for being a transgender girl.²³⁸ L.L. said that staff told her parents

²²⁴ *Id.*

²²⁵ *Id.*; see also Stockton, *supra* note 221.

²²⁶ Krebs, *supra* note 221.

²²⁷ Affidavit of L.L. ¶ 5, Pool v. Richardson, No. 2021 DRB 1542 (D.C. Super. Ct. executed Sept. 28, 2021).

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ See *id.*

²³² *Id.* ¶¶ 2, 5.

²³³ *Id.* ¶ 6.

²³⁴ *Id.* ¶ 8.

²³⁵ *Id.* ¶ 9.

²³⁶ *Id.* ¶¶ 11, 14.

²³⁷ *Id.* ¶¶ 11–12.

²³⁸ *Id.* ¶ 7.

it was “not uncommon for teenagers to say they are transgender to lash out or seek attention” and that Elevations could help L.L. change.²³⁹ L.L. reported that her therapist at Elevations told her that being a girl was “just a façade, not the ‘real [her]’, and that [she] must change it and identify as male.”²⁴⁰ L.L. said her therapist “directed other staff to deny [L.L.’s] identity” and “punish any attempt on [L.L.’s] part to express [her]self outside of mandated masculine stereotypes.”²⁴¹ According to L.L., when she refused to cut her hair, Elevations told her she was not making satisfactory progress.²⁴² In addition, according to her affidavit, when L.L. asked for a different counselor, Elevations denied her request.²⁴³

L.L. reported that throughout her time at Elevations, she was physically, verbally, and sexually harassed by residents, and staff rarely intervened to stop the abuse.²⁴⁴ According to her sworn statement, when L.L. complained to administrators about the harassment, they called her a liar.²⁴⁵ In addition, she explained that unlicensed and inexperienced dormitory staff led therapeutic groups that regularly required youth to criticize each other and relive traumatic events in the name of “vulnerability” and “growth,” resulting in the humiliation and retraumatization of youth and, frequently, the use of physical force against them.²⁴⁶ As L.L. explained, “[t]he system was designed to be manipulative and toxic and to bring out the worst in the kids. It aided and abetted them in being harassing.”²⁴⁷

Toward the end of her stay, as L.L. explained, Elevations placed her in isolation for over a month, where she was forced to sit in her room at a desk, all day.²⁴⁸ She could not talk to anyone.²⁴⁹ Although Elevations promised to help, L.L. said the experience only harmed her. “In addition to the trauma,” she explained:

I lost two years of my childhood. I was disconnected from my family and community. I wasn’t allowed to talk to anyone I knew. I wasn’t even allowed to return home to visit my family. I lost what feels like so much of my life there and was left with so much pain. . . . So much energy and time and money went into suppressing my gender identity and expression. My treatment there made me doubt reality. It made me feel as though I was going insane.²⁵⁰

²³⁹ *Id.*

²⁴⁰ *Id.* ¶ 20.

²⁴¹ *Id.*

²⁴² *Id.* ¶ 23.

²⁴³ *Id.* ¶ 21.

²⁴⁴ *Id.* ¶¶ 15–16.

²⁴⁵ *Id.* ¶ 17.

²⁴⁶ *Id.* ¶ 19.

²⁴⁷ *Id.* ¶ 31.

²⁴⁸ *Id.* ¶ 24.

²⁴⁹ *Id.* ¶¶ 24, 32.

²⁵⁰ *Id.* ¶¶ 32–33.

L.L.'s story is just one of thousands experienced by LGBTQ youth who are locked away, often by schools and foster care systems un-equipped to provide the support that youth need.²⁵¹ As her experience illustrates, the troubled teen industry is plagued by disturbing features that fly in the face of evidence-based medicine. First, and of greatest significance to this Review, is the industry's pervasive and ubiquitous engagement in conversion practices. Facilities attempt to change the gender identity or sexual orientation of youth in supposed "counseling sessions" where youth are regularly and repeatedly told that being transgender is "a façade" and a means of "seeking attention and lashing out against . . . parents," that trans youth "are not trans," and that it's "better to be" one's birth sex.²⁵² These facilities also attempt to change gender identity and sexual orientation through behavioral conditioning. They force LGBTQ youth to suppress their gender identity and sexual orientation in order to avoid rampant harassment, abuse, and punishment by residents and staff,²⁵³ and to "progress" in their treatment so that they will one day be able to leave the facility.²⁵⁴ In short, the troubled teen industry forces LGBTQ youth to hide their gender nonconformity in order to survive.²⁵⁵

²⁵¹ See Robert, *supra* note 220, at 49.

²⁵² Affidavit of L.L., *supra* note 227, ¶¶ 13, 20; Affidavit of S.B. ¶ 20, *Pool*, No. 2021 DRB 1542 (executed Sept. 24, 2021).

²⁵³ See, e.g., Affidavit of S.D. ¶¶ 16, 18, *Pool*, No. 2021 DRB 1542 (executed Sept. 20, 2021) ("There were a lot of transgender kids at Elevations, and they often experienced intense bullying from other kids, which staff did not do anything about. Many times, staff members themselves would be disrespectful to transgender kids. . . . I also saw transgender kids violently restrained by staff for no legitimate reason."); Affidavit of W.T. ¶ 11, *Pool*, No. 2021 DRB 1542 (executed Sept. 21, 2021) ("During my time at Elevations, there was a kid who constantly harassed me for being transgender. He would scream down the hall at me, 'hey pussy boy' . . . [and] try[] to grab my chest. I had top surgery only a few months before getting to Elevations, and I was very protective of my chest, so this was extremely upsetting to me. I talked to my therapist . . . about it, and he would just say, 'you're not helping the situation.'"); Affidavit of C.W. ¶ 25, *Pool*, No. 2021 DRB 1542 (executed Sept. 27, 2021) ("I am straight, but I didn't see any support for LGBT kids when I was there, and kids who were gay or transgender were constantly harassed. I remember we were not allowed to refer to a transgender kid on the team with their proper pronouns. Staff went as far as making up a new name for them, forcing us to refer to them using this name, and justifying their decision as being 'part of their therapy.'"); Affidavit of O.B. ¶ 8, *Pool*, No. 2021 DRB 1542 (executed Sept. 20, 2021) ("[O]ther kids would constantly bully and harass me for being transgender. . . . At one point, I was physically assaulted by another student who elbowed me in the chest so hard that I fe[ll] down. Even though staff saw this, they didn't punish him. The other boys would also call me 'tranny' or other derogatory names. Staff never did anything to stop that either.").

²⁵⁴ See Affidavit of L.L., *supra* note 227, ¶ 23.

²⁵⁵ Affidavit of C.C. ¶¶ 16–17, *Pool*, No. 2021 DRB 1542 (executed Sept. 28, 2021) (explaining that they did not "talk about [their] gender shit at all" because "kids who talked about being transgender were bullied by other kids and staff, and because the therapists would use being transgender against [kids]," and noting that, while in treatment, they wrote: "I'm ready to give up and just bullshit. I'm a treatment robot now"). Other survivors of the troubled teen industry have come forward to describe the conversion practices they have experienced. See, e.g., Rachel Aviv, *The Shadow Penal System for Struggling Kids*, *NEW YORKER* (Oct. 11, 2021), <https://>

Second, because these facilities are driven by profit motives, they are incentivized to not properly screen children to ensure that residential treatment for addiction and mental health conditions is necessary, or even appropriate. Therapeutic placements are inappropriate and, in fact, harmful for the vast majority of youth,²⁵⁶ and they are never appropriate just because a youth is LGBTQ.²⁵⁷ According to clinical experts, “residential care is appropriate only for a small minority of youth” who are experiencing acute, severe mental health issues, such as psychosis, suicidality, or addictive disorders with a physical-dependence component (for instance, opioid or severe alcohol addiction).²⁵⁸ For those who do not meet strict criteria, residential treatment is not appropriate.²⁵⁹ Such treatment should never be used as a “convenience tool” for parents; “although family preference . . . should be important in making decisions, parental preference alone should not be a reason to choose a highly restrictive setting such as residential care.”²⁶⁰ Youth with less acute mental health challenges need care that maximizes their resilience, builds their self-esteem, supports development of regulation and executive function, and strengthens connection to family and other ongoing support systems.²⁶¹ Even in those rare cases in which youth residential care is appropriate, “the length-of-stay is appropriately very brief, typically lasting a few weeks.”²⁶²

The troubled teen industry is often a dumping ground for youth — many of them LGBTQ — who are experiencing conflict with parents or exhibiting mental health concerns that are better addressed in a community, outpatient setting.²⁶³ For example, many children are placed in residential treatment centers “in the context of custody disputes between parents, either because the family situation is upsetting to a child and they may be acting out, or because one of the parents does not really want custody but also does not want the other parent to have

www.newyorker.com/magazine/2021/10/18/the-shadow-penal-system-for-struggling-kids [https://perma.cc/NG6D-ZSU3]; Hailey Branson-Potts, *L.A. Legislator, Activists Say Gay Conversion Therapy Still Exists*, L.A. TIMES (Mar. 27, 2015, 4:17 PM), <https://www.latimes.com/local/lanow/la-me-ln-troubled-teen-home-regulation-20150327-story.html> [https://perma.cc/37ZT-3H2R].

²⁵⁶ Affidavit of Mira Jourdan-Krishnan, PhD, ABPP ¶ 6, *Pool*, No. 2021 DRB 1542 (executed Sept. 29, 2021).

²⁵⁷ *See id.* ¶ 9.

²⁵⁸ *Id.* ¶ 6; *see* Affidavit of Maia Szalavitz ¶ 5, *Pool*, No. 2021 DRB 1542 (executed Sept. 20, 2021).

²⁵⁹ Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶¶ 5–6.

²⁶⁰ *Id.* ¶ 8.

²⁶¹ *See id.* ¶ 9.

²⁶² *Id.* ¶ 8.

²⁶³ *Id.* ¶ 11; Affidavit of Maia Szalavitz, *supra* note 258, ¶ 4; Karen Ocamb, *Schiff Reintroduces Bill to Regulate “Troubled Teen” Industry*, WASH. BLADE (June 22, 2017), <https://www.washingtonblade.com/2017/06/22/stop-child-abuse> [https://perma.cc/F8WM-JJ9M]; *see also* Affidavit of S.B., *supra* note 252, ¶ 3 (“My parents sent me to Elevations when I was sixteen because they didn’t know how to deal with me being gay or trans.”).

custody.”²⁶⁴ Accordingly, many troubled teen facilities “provide treatment to children who do not need residential care,” and they do so for months and sometimes years, simply to turn a profit.²⁶⁵ These facilities also engage in deceptive marketing — telling parents that long-term residential placement is beneficial and that removing youth from such care will jeopardize their children’s health and well-being — neither of which is true.²⁶⁶

Third, many troubled teen facilities utilize approaches that are “coercive, punitive, and even draconian,” rather than safe, nurturing, and therapeutic.²⁶⁷ According to experts, evidence-based care in residential facilities includes providing formal individual and family psychotherapy by qualified mental health professionals, maximizing family involvement and access, obtaining youth assent to treatment, and striving to create an environment that is noncoercive — with physical restraint and seclusion used only as a last resort for safety, and never for punishment.²⁶⁸

Most troubled teen facilities do none of these things. Staff at many facilities are not well qualified: they are often not required to have a high school degree, let alone graduate-level education, and the vast majority have no real mental health training.²⁶⁹ Such facilities also adopt a “one-size-fits-all” approach to treatment that offers no therapeutic benefit, “mingl[ing] children who have vastly different mental health situations and issues” and putting them “in the same groups, with the same staff, and the same rules.”²⁷⁰

Additionally, many troubled teen facilities are blatantly prison-like.²⁷¹ Third-party escort services “kidnap” children from their homes

²⁶⁴ Affidavit of Maia Szalavitz, *supra* note 258, ¶ 4.

²⁶⁵ *Id.* ¶ 6; *see also* Affidavit of L.L., *supra* note 227, ¶ 6 (“In total, I spent 715 days in these facilities, just shy of two years.”); Affidavit of O.B., *supra* note 253, ¶ 2 (“I ended up spending almost a year and a half at the facility”); Affidavit of S.B., *supra* note 252, ¶¶ 2, 8 (seven to eight months).

²⁶⁶ Affidavit of Maia Szalavitz, *supra* note 258, ¶ 17.

²⁶⁷ Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶¶ 12–13; *see* Affidavit of Maia Szalavitz, *supra* note 258, ¶¶ 6–7.

²⁶⁸ Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶¶ 9, 13.

²⁶⁹ *See id.* ¶ 14; Affidavit of Maia Szalavitz, *supra* note 258, ¶¶ 7, 9; Affidavit of L.L., *supra* note 227, ¶ 19 (“Unlicensed and inexperienced dormitory staff conducted therapeutic groups”).

²⁷⁰ Affidavit of Maia Szalavitz, *supra* note 258, ¶ 7; *see id.* ¶ 10; Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶ 12.

²⁷¹ *See, e.g.*, Affidavit of O.B., *supra* note 253, ¶ 4 (“The physical surroundings are prison-like. The residents are locked in at all times and must earn even basic ‘privileges,’ like being able to email parents, by winning ‘points’ and getting onto new ‘levels’ by conforming to strict rules about every aspect of your behavior. The atmosphere is punitive and extremely controlling.”); Affidavit of S.D., *supra* note 253, ¶ 22 (“The program there is like Big Brother, only worse.”); *see also* Stockton, *supra* note 221 (equating residential treatment centers to “low-security prisons”).

in the middle of the night and transport them to residential facilities.²⁷² Once there, youth must abide by rigid token (reward-and-punishment) systems that “demand[] performative obedience from youth in order to have their basic dignity recognized” and deprive them of control over virtually all aspects of their lives — including whether and when they will be able to leave the facility.²⁷³ Staff employ physical restraint and prolonged seclusion frequently and as punishment.²⁷⁴ Doors are locked, youth access to family and friends is extremely limited, communications among youth and between youth and parents are heavily monitored, rooms are regularly searched, and youths are regularly strip searched.²⁷⁵ Parents are told to trust the facility and to distrust their children when they speak out against the facility.²⁷⁶ And inadequate staffing ratios, as well as poor training and lack of supervision of staff, result in rampant bullying and harassment of youth — particularly LGBTQ youth — by staff and residents.²⁷⁷

There is a well-established history that residential facilities with punitive features like these do not *treat* children — they traumatize children.²⁷⁸ Survivors of troubled teen facilities report having nightmares of being in isolation or physically restrained, experiencing PTSD, struggling with drug abuse and suicidality, severing ties with their parents

²⁷² Affidavit of C.W., *supra* note 253, ¶ 4; Affidavit of S.B., *supra* note 252, ¶ 6; Affidavit of S.O. ¶ 21, *Pool v. Richardson*, No. 2021 DRB 1542 (D.C. Super. Ct. executed Sept. 27, 2021); *see also* Affidavit of L.L., *supra* note 227, ¶ 5; Jesse Hyde, *Life and Death in a Troubled Teen Boot Camp*, ROLLING STONE (Nov. 12, 2015), <https://www.rollingstone.com/culture/culture-news/life-and-death-in-a-troubled-teen-boot-camp-31639> [<https://perma.cc/MCR8-U8UT>]; Robert, *supra* note 220, at 48 (discussing “legal[] kidnapp[ing] and traffick[ing]” of children across state and border lines to residential treatment centers); Jessica Miller, David Fuchs & Will Craft, “*Blindfolds, Hoods and Handcuffs*”: *How Some Teenagers Get to Utah’s Youth Treatment Programs*, APM REPORTS (Mar. 8, 2022), <https://www.apmreports.org/story/2022/03/08/how-teenagers-get-to-utah-youth-treatment-programs> [<https://perma.cc/PU2C-JX29>] (“[Troubled teen facilities] sometimes send staff . . . to retrieve children. Parents can also hire a ‘secure transport’ company whose sole purpose is to shepherd teens to treatment centers.”).

²⁷³ Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶ 15; Affidavit of Maia Szalavitz, *supra* note 258, ¶¶ 11–12; *see also* Affidavit of S.O., *supra* note 272, ¶¶ 7–8 (describing point-and-level system); Affidavit of O.B., *supra* note 253, ¶ 4 (same).

²⁷⁴ *See, e.g.*, Affidavit of S.B., *supra* note 252, ¶ 25 (“I was put on . . . isolation[] for kissing a girl. I was in [isolation] for a month.”); Affidavit of C.W., *supra* note 253, ¶ 7 (discussing staff’s frequent use of physical restraint, also known as “chicken-wing[ing],” which was done “for just about any reason, such as a kid not wanting to clean up their room or talking back to staff. Two grown adults, usually men, would get on either side of you, take your wrists and bend your hand down until it hurt so bad that you gave up. Often the nurse would come and do a range of motion test afterward to make sure they hadn’t caused any fractures”).

²⁷⁵ *See* Affidavit of O.B., *supra* note 253, ¶ 12; Affidavit of S.D., *supra* note 253, ¶ 26; Affidavit of S.O., *supra* note 272, ¶ 15.

²⁷⁶ *See* Affidavit of C.M. ¶ 4, *Pool*, No. 2021 DRB 1542 (executed Sept. 23, 2021) (“[P]arents are told by staff beforehand that your child is going to lie to you to try to leave, so the parents should not believe anything their kids say.”).

²⁷⁷ *See* Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶ 14; Affidavit of Maia Szalavitz, *supra* note 258, ¶¶ 7, 9; *see sources cited supra* note 253 (discussing harassment of LGBTQ youth).

²⁷⁸ *See* Affidavit of Mira Jourdan-Krishnan, PhD, ABPP, *supra* note 256, ¶ 16.

whom they no longer trust, and, tragically, learning of the deaths of other survivors by suicide, drug overdose, and violence.²⁷⁹ As one trans survivor wrote:

I was able to stay in contact with a few people who were at Elevations with me. Many of them have taken their lives since then. I also definitely have thought about that, too. Most of them were queer. We stayed in contact for as long as we could, would talk about stuff that happened to us, about being back in the real world after those several months there, and about trying to adjust. For some of them, it was just too big of a thing that had happened to go back to living a normal life.²⁸⁰

Not surprisingly, many parents who send their children to such facilities later express guilt and regret.²⁸¹

Given these horrific realities, regulation of troubled teen facilities and investigation of youth complaints are critical. Because these facilities treat youth and employ licensed professionals,²⁸² laws banning conversion practices apply to them. Licensed professionals who engage in conversion practices at these facilities should therefore be subject to professional discipline. In states without bans, the existence of troubled teen facilities presents grassroots advocates with an additional, powerful reason to urge policymakers to support the passage of such bans.

Regulation of the troubled teen industry should also extend beyond the enforcement of bans on conversion practices. In 2020, for example, Oregon passed legislation mandating that out-of-state facilities that treat Oregon youth must be licensed with the state's department of human services and comply with the same regulations as facilities located in Oregon.²⁸³ California, Montana, and Missouri have also passed legislation aimed at increasing oversight of residential treatment facilities for young people.²⁸⁴ Federal legislation to regulate the troubled teen

²⁷⁹ See Affidavit of C.C., *supra* note 255, ¶¶ 20–22; Affidavit of C.W., *supra* note 253, ¶¶ 27–28; Affidavit of C.M., *supra* note 276, ¶ 24; Affidavit of L.L., *supra* note 227, ¶ 26; Affidavit of S.O., *supra* note 272, ¶ 21.

²⁸⁰ Affidavit of S.B., *supra* note 252, ¶ 17.

²⁸¹ Kelly-Leigh Cooper, *Troubled US Teens Left Traumatized by Tough Love Camps*, BBC NEWS (June 19, 2021), <https://www.bbc.com/news/world-us-canada-57442175> [<https://perma.cc/7U8B-JM3D>]; Affidavit of S.D., *supra* note 253, ¶ 28 (“My parents are very sorry they put me into Elevations, and that means a lot to me. I know they were misled by Elevations staff and told not to believe anything I said. My parents feel extreme guilt about putting me there, and I have seen them cry over sending me there.”).

²⁸² Robert, *supra* note 220, at 52. The National Association of Therapeutic Schools and Programs, the industry's largest nonprofit trade association, requires that “adolescent programs, in addition to having a licensed clinician, have to be licensed by their state or accredited by a national accrediting body like the Joint Commission.” *Id.*

²⁸³ *Id.* at 53.

²⁸⁴ Cameron Evans, *State Laws Aim to Regulate “Troubled Teen Industry,” But Loopholes Remain*, KAISER HEALTH NEWS (Jan. 21, 2022), <https://khn.org/news/article/state-laws-aim-to-regulate-troubled-teen-industry-but-loopholes-remain> [<https://perma.cc/US5U-WWZQ>].

industry was repeatedly introduced in Congress between 2007 and 2017 but never enacted.²⁸⁵

CONCLUSION

We live in an era defined by extraordinary attempts to politicize medical care and to reinstate government-enforced restrictions based on sex stereotypes, ranging from abortion bans to laws criminalizing the provision of medically necessary care to transgender minors. Conversion practices, the topic of this Review, represent a particularly dangerous manifestation of these trends: the rejection of evidence-based care in favor of blatantly ideological attempts to channel children's identities into traditional gender norms, notwithstanding the complete absence of credible evidence that such efforts work and mounting evidence that they put youth at risk of serious harms.

For the reasons discussed in this Review, governments and other regulatory bodies should continue to protect minors from conversion practices. Such measures fall squarely within the state's longstanding authority to regulate the practice of medicine to protect public health and safety. These prohibitions should be enacted where they do not yet exist and rigorously enforced where they do, including against practitioners in the "troubled teen industry." At a minimum, the law should not stand idly by while state-licensed mental health providers inflict unnecessary harm on vulnerable youth. Legislative bans, "although not a panacea" (p. 17), are vital to ending conversion practices, and to advancing the broader goal of protecting the health and well-being of all children regardless of their sexual orientation or gender identity.

²⁸⁵ See *id.*; see, e.g., Stop Child Abuse in Residential Programs for Teens Act, H.R. 3024, 115th Cong. (2017).