Ohio Psychological Association: Official Statement

OPA Response to HB 454

November 11, 2021
Written by: The Ohio Psychological Association’s Board of Directors and LGBT+ Sub-Committee

The Ohio Psychological Association opposes HB 454. Psychologists represented by the Ohio Psychological Association view the bill as harmful to the well-being of our clients. The bill reflects ignorance and intolerance of sensitive and personal gender-related issues. The bill makes unfounded claims and prejudicial statements for rationale and ignores a solid body of research as to the dangers inherent in depriving a vulnerable population of needed medical and psychological care. The bill takes an overly simplistic and moralistic approach to a very complicated set of psychological and medical issues.

Language contained in HB 454 suggests that children and adolescents who seek services around issues pertaining to their gender identity are mentally ill or “dysphoric.” The stated premise is that these children and teens have so-called “gender dysphoria” and are being treated with procedures that are “experimental.”

Two statements made in the legislation are completely false and unsupported in the present professional literature:

D) Scientific studies show that individuals struggling with distress at identifying with their biological sex often have already experienced psychopathology, which indicates these individuals should be encouraged to seek mental health care services before undertaking any hormonal or surgical intervention;

E) Suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated above the background population after inpatient gender reassignment procedures have been performed;

The American Psychiatric Association emphasizes in the DSM-5 that individuals experiencing distress around issues of gender identity are not mentally ill. The dysphoria experienced about gender identity is more often not about the gender identity issues themselves but about a lack of support and understanding for their gender identity from family and their surrounding community.

The DSM 5 states clearly that one’s gender identity being different than one’s gender defined by biology is not a mental disorder. It states “the current term gender dysphoria is more descriptive than the previous DSM-4 term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se.” (American Psychiatric Association, 2013)
There is considerable evidence that suicidal thoughts and behavior among persons who are transgender or gender non-conforming results not from dysphoria about a struggle over identity but because of an absence of support for them, including medical care and psychological care that affirms the identity to which a person ascribes. The following is from the American Psychological Association’s Guidelines for the Psychological Treatment of Transgender and Gender Non-conforming People (American Psychological Association, 2015).

Many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Bazargan & Galvan, 2012; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011).

In a national representative sample of 7,898 LGBT youth in K-12 settings, 55.2% of participants reported verbal harassment, 22.7% reported physical harassment, and 11.4% reported physical assault based on their gender expression (Kosciw, Greytak, Palmer, & Boesen, 2014). In a national community survey of TGNC adults, 15% reported prematurely leaving educational settings ranging from kindergarten through college as a result of harassment (Grant et al., 2011).

Research has primarily shown positive treatment outcomes when TGNC adults and adolescents receive TGNC-affirmative medical and psychological services (i.e., psychotherapy, hormones, surgery; Byne et al., 2012; R. Carroll, 1999; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Davis & Meier, 2014; De Cuypere et al., 2006; Gooren, Giltay, & Banck, 2008; Kuhn et al., 2009), although sample sizes are frequently small with no population-based studies.

In a meta-analysis of the hormone therapy treatment literature with TGNC adults and adolescents, researchers reported that 80% of participants receiving trans-affirmative care experienced an improved quality of life, decreased gender dysphoria, and a reduction in negative psychological symptoms (Murad et al., 2010). In addition, TGNC people who receive social support about their gender identity and gender expression have improved outcomes and quality of life (Brill & Pepper, 2008; Pinto, Melendez, & Spector, 2008).

Several studies indicate that family acceptance of TGNC adolescents and adults is associated with decreased rates of negative outcomes, such as depression, suicide, and HIV risk behaviors and infection (Bockting et al., 2013; Dhejne et al., 2011; Grant et al., 2011; Liu & Mustanski, 2012; Ryan, 2009). Family support is also a strong protective factor for TGNC adults and adolescents (Bockting et al., 2013; Moody & Smith, 2013; Ryan et al., 2010).

TGNC people, however, frequently experience blatant or subtle antitrans prejudice, discrimination, and even violence within their families (Bradford et al., 2007). Such family rejection is associated with higher rates of HIV infection, suicide, incarceration, and homelessness for TGNC adults and adolescents (Grant et al., 2011; Liu & Mustanski, 2012). Family rejection and lower levels of social support are significantly correlated with depression (Clements-Nolle et al., 2006; Ryan, 2009).
Many TGN/C people seek support through peer relationships chosen families, and communities in which they may be more likely to experience acceptance (Gonzalez & McNulty, 2010; Nuttbrock et al., 2009). Peer support from other TGN/C people has been found to be a moderator between antitrans discrimination and mental health, with higher levels of peer support associated with better mental health (Bockting et al., 2013).

For some TGN/C people, support from religious and spiritual communities provides an important source of resilience (Glaser, 2008; Kidd & Witten, 2008; Porter et al., 2013). (American Psychological Association, 2015)

HB 454 states the following:

(C) Studies consistently demonstrate that the vast majority of children who are gender non-conforming or experience distress at identifying with their biological sex come to identify with their biological sex in adolescence or adulthood, thereby rendering most medical health care interventions unnecessary;

This statement is not supported by the available evidence. It is true that many children do not persist in identifying with a gender other than the gender they were born with. (American Psychological Association, 2015). It is not known the percentage that persist in an alternate gender identity or the numbers that return to identification with the gender of their birth because of the difficulty tracking the outcome of children who cease coming to clinics for follow-up. (The American Psychological Association, 2015).

However, research favors allowing a child the freedom to explore, rather than attempting to force the child to adopt the gender they were born with. (American Psychological Association, 2015). There is no evidence to suggest that a child’s course can be altered by any particular approach. But, current research suggests that supportive approaches are favored over coercion to identify with one’s gender assigned at birth.

Research suggests that teens are different. Most teens, whether they identify with the gender of their birth or if they are transgender or gender non-conforming, persist in adopting the gender they feel most comfortable with. Identity cannot be forced by external means. The only question is whether their parents and communities accept or reject them. The absence of support, the unavailability of affirming care and services, stigma, harassment and other forms of rejection seems to lead to adverse outcomes in terms of mental health, physical health, and suicidality. (The American Psychological Association, 2015)

Section 329.04 of HB 454 states:

Any provision of gender transition procedures to a person under eighteen years of age shall be considered unprofessional conduct and shall be subject to discipline by the licensing entity with jurisdiction over the physician, mental health provider, or other medical health care professional.
This and other limits placed on medical providers is problematic in many ways.

This legislation is dangerous and intrusive because it puts the State of Ohio into the consulting room and places a wedge between a client or patient and provider. It makes the State a client or party to the private provider-client relationship and advances a State or political, rather than a clinical interest in directing medical and psychological care. It interferes with sensitive, personal, and private medical conversations and adversely impacts the provider-client relationship. It violates HIPPA and other privacy laws.

There are ethics guiding psychologists, physicians, and other providers which are in direct opposition to what this legislation dictates. Such legislation would result in the provider deciding between the provision of competent and ethical care and following State law.

The legislation also errs in the assumption that affirming care is experimental and unsupported by research or standards of practice. Gender-affirming care, that which acknowledges and supports a child or teen’s gender identity, has been practiced competently for more than 20 years. Ohio’s major medical centers and academic institutions, including the State’s children’s hospitals and the Veteran’s Administration have well-established clinics and programs devoted to the provision of gender-affirming care for children, youths, and adults.

The use of puberty-blockers has existed for years in standard child medical practice to delay precocious puberty. The use of hormones to treat growth and other endocrine conditions is also well-established as being safe and effective. (Scientific American April 9, 2021).

Finally, the legislation assumes that parents are excluded from the process when gender-affirming care is provided to children and youths. Providers generally involve parents.

It is true that parents are sometimes unsupportive and this becomes a challenge for providers. However, it is the experience of most providers that parents are often very supportive and drive the gender-affirming care their children receive from providers. Those parents who struggle with supporting their children are usually approached with empathy, education and professionalism.

Of course, there will always be parents who are not supportive of their children or teens around certain issues. Choose the issue: choice of a sport, choice of hairstyle, choice of a career, whether or not to attend college, whom to marry. Any number of issues may put a child or teen at odds with their parents. What side will the State take on these issues or in deciding when a parent’s opinion may be appropriately discounted in a teen’s decision-making process?

**References:**

References used by the American Psychological Association to create Guidelines for Psychological Practice with Transgender and Gender Nonconforming People and incorporated in this statement:


###

The Ohio Psychological Association, in Columbus, Ohio, is membership organization of approximately 1,500 Ohio psychologists. Its mission is to advance psychology as a science, as a profession and as a means of promoting human welfare. For more information or for a psychologist referral, visit www.ohpsych.org.