I write to oppose HB 2458. I have been an Oregon resident for 17 years, I have close family members and friends who are gay, bisexual or gender non-conforming, including some who have undergone or sought permanent medical procedures on account of this, and I fully support gay, trans, and non-normative gender/gender expressing people of all orientations and their rights. This includes my support for their access to the best therapy and healthcare available. Unfortunately, HB 2458 may serve to hinder the best care for those who experience gender dysphoria or who identify as transgender.

HB 2458 risks hindering best care outcomes primarily because the narratives surrounding this Bill, and the language of the Bill itself obfuscates the modern context of gender dysphoria and transgender issues. This narrative mistakenly confuses "conversion therapy", as known within the context and history of gay, lesbian or bi-sexual orientation, with "conversion therapy" for the gender dysphoric or trans-identified, the latter of which demands qualifiers and clarifications that the open definition of "conversion therapy" as written in this Bill does not provide. In fact, "conversion therapy" as a type of therapy for the gender-dysphoric or trans-identified is almost a wholly incoherent use of language that would intend to apply prohibitions to practice.

Sexual orientation, as a matter of gay rights, has a clear definition by dint of one's sexual preferences, for which the history of conversion therapy as a method or attempt to reverse these libidinal desires is obviously regressive to the health of an individual.

By contrast, it is not clear that all who experience gender dysphoria will remain gender-dysphoric, nor is there a way to determine who among them will decide to transition in some way, nor even are all cases of transition a result of true dysphoria. Gender dysphoria and transgender identification may describe symptoms or anxieties that arise as a result of trauma or sexual trauma, comorbidities or conditions such as autism, OCD or anxiety disorders, simple gender non-conforming behaviors, and more. Meanwhile, the path to transition - primarily when transition involves medicalization - entails a number of treatments that are mostly irreversible, including hormones and surgery. Given this, it is the belief of a great number of counselors that the many causes of gender distress require the availability and exploration of many routes out of it.

It only took me a few clicks to find clinical psychologists and experts who submitted testimony in opposition to this bill who have verified this prevalence of comorbidities. It only took a few more clicks to find the testimony of parents whose' adolescent children identified as trans, only to later desist. More scrutiny is targeting the lack of adequate data or unreliability of studies that assert positive outcomes of transitioning. In doing the research myself, I've noticed a pattern of worse outcomes the more qualitatively sound the studies get. More anecdotally, the recent public detransition stories of Chloe Cole and Scott Newgent both in the United States, and Ritchie Herron in Britain make clear the risks of embarking on medical transition without proper therapeutic guidance, while it is worthy of note that both Herron and Newgent transitioned after the age of 18, only to experience regret and grave medical and health consequences. More overwhelmingly, the "r/Detrans" reddit forum - a moderated discussion board of detransition stories updated every day - has over 44k members, up from 30k just last year. For those studying the issue in depth,it is a matter of cruel necessity that the surge in medical transitions is such a recent phenomenon (only in the past 10 years), while the subsequent fallout of detransitioners telling their stories comes at a time when there are no long-term studies to verify the positive outcomes of medical transition.

Positive outcomes do exist; however, this does not contradict the fact that transgender identification is a complex identification that any responsible care should seek to isolate or weigh alongside the consideration of multiple variables that may be impacting a person's life for a full psychological profile. Because of the vagueness of what is meant by "conversion therapy" as written in this Bill, it is not clear, for instance, whether the practice of "watchful waiting" as adopted by some clinicians, or even simple explorative counseling might be labeled as "conversion therapy", when it may be essential for the best outcomes. In this context, it should be noted that the United Kingdom, Sweden and Finland have all reversed course on their gender-affirmative treatment protocols after reviewing their own evidence.

I implore you to consider the layers involved for any therapy a counselor might pursue in order to establish a strong understanding of their clients, the highly politically-charged atmosphere surrounding this issue and career-jeopardizing risks they stand to endure for pursuing a responsible care model that may deviate from the "affirmative care" model, and listen to the experts and clinicians who have serious reservations about the outcomes the passage of this Bill may portend despite its best intentions.