To: State Board of Education
State of Michigan Department of Education
Lansing, Michigan

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RE: State Board of Education Statement and Guidance on Safe and Supportive Learning Environments for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Students

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Dear Members of the State Board of Education:

From twelve years of studying the professional division over the treatment of homosexuality and gender identity disorder, I am convinced that the State Board of Education's LGBTQ statement and guidance proposal will work in opposition to the goal of making Michigan a top ten performing state in the area of education. The guiding principle of being a "Top 10 in 10 Years" is to produce a "Can-Do Culture that focuses on student-directed learning and student outcomes" (MDE, 2015). Key to achieving such a goal was to "use evidence and data" (MDE, 2015).

Evidence and data on homosexuality and gender identity used by the SBE appears to mirror LGBTQ political goals. If the State Board of Education is going to serve students and parents fairly they need to research all the evidence and make decisions that protect the best interests of all students.

An examination of all the facts leads to the conclusions reached by the American College of Pediatricians (ACP). One of which reads,

> **Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse.** Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to "gender clinics" where they will be given puberty-blocking drugs. This, in turn, virtually ensures that they will "choose" a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults (ACP, 2016).

The ACP points out that most youth who identify as transgender will "eventually accept reality and achieve a state of mental and physical health" (ACP, 2015). Similarly, surveys of sexual orientation have consistently found that most youth who engage in homosexual activity, do not do so in their adulthood. Alfred Kinsey's surveys even showed this fact. The Kinsey male survey reported that 37 percent of the male population had "… **at least some overt homosexual experience**," but only 4 percent remained "**exclusively homosexual throughout their lives**" (Kinsey et al., 1948, p. 650-1). Given the figures used by SBE that 8.4 percent of high school students identify as lesbian, gay, or bisexual, in adulthood less than 4 percent will identify as LGB. The same applies to transgender students. How schools respond to the insecurities and confusion experienced by these students will move the figures one way or the other. If the schools help sexually confused students identify with their biologically determined gender and corresponding masculinity or femininity, then more students will reach adulthood with a gender identity corresponding to their biological gender. If the schools reinforce the normalcy of homosexual and transgender identities, then more students will adopt those identities as permanent manifestations of their personality.

Given the health risks associated with homosexuality and transgender identities, common sense dictates that the school system help as many students as possible obtain a healthy heterosexual adjustment and a gender identity that corresponds to their biological sex. Male homosexual behavior is one of the greatest health risks in the nation. The Centers for Disease Control and Prevention (CDC) reported that in 2014 that "MSM [men who have sex with men] accounted for 82.9% of all male P&S [primary and secondary] syphilis cases with known information about sex of sex partners" (CDC, 2015, STDs). The risk of HIV infection is just as great. "In 2013, in the United States, gay and bisexual men accounted for 81% (30,689) of the 37,887 estimated HIV diagnoses among all males aged 13 years and older" (CDC, 2015, HIV). Compared to CDC statistics on smoking tobacco, the risks from male homosexual behavior dwarf the risks from smoking tobacco. Yet, LGBTQ political interests have persuaded many educators that homosexual behavior should be promoted as equal to heterosexual behavior.

Let me give you one example of how encouraging a transgender identity is harmful. I attended a forum on understanding transgender individuals at the University of Michigan-Flint several years ago. It was sponsored by the U of M-Flint LGBT department – the Ellen Bommarito LGBT Center Services. One of the transgender students that spoke was a male of about twenty years of age. A reason he gave for looking forward to a sex change surgery was that he had heard that transsexuals were in high demand in the prostitution trade. The faculty member at the event did not discourage this ambition, nor did any of the other attendees. All were supportive of this self-destructive plan.

Many prominent psychiatrists and psychotherapists have recommended helping sexually confused youth to identify with their biological gender, including methods to help them develop their corresponding masculinity or femininity (Stekel & Frohman, 1930; Henry, 1937; Brown, 1958; West, 1959; Glover, 1960; Bieber, 1967; Karpman, 1964; Marmor, 1965; Bene, 1965; Shearer, 1966; Bakwin, 1968; Gershman, 1975; Socarides, 1975; Stoller, 1978; Nicolosi & Nicolosi, 2002). These mental health professionals believed the clinical evidence showed that many young people could and can be guided to embrace their biological gender and its corresponding masculinity or femininity. In recent history their viewpoints have been disregarded for LGBTQ political objectives.

The history of disregarding the clinical evidence on homosexuality goes back to Gerald Davison, a gay psychologist, who was elected president of Association for the Advancement of Behavior Therapy in 1974. In his presidential address before the Association he argued that therapists should refuse to help homosexuals who desired to change their sexual orientation. He acknowledged that individual homosexuals might suffer if therapists adopted his perspective, but contended that homosexuals as a socio-cultural group would benefit. This perspective has been taken up by the LGBTQ political movement and its imprint is all over the SBE statement and guidelines for LGBTQ students. Historian Ronald Bayer commented on this homosexual political strategy: "The political standard of social justice was thus given preeminence over the clinical standard. The interest of 'the homosexual' was given priority over the desires of individual homosexuals" (Bayer, 1981, p. 188). In a similar way the SBE's LGBTQ statement and guidance proposal puts the LGBTQ political interests of normalizing homosexuality and gender identity disorder over the interests of students who are confused in their gender identity and sexual orientation.

Even the higher rates of suicide for LGBTQ youth have been used for political purposes. LGBTQ political interests claim the higher rates are due to "homophobia," in particular, attitudes that disapprove of homosexuality. They claim societal approval will lower the number of these suicides. Clinical science does not agree with their argument. In 1954 psychotherapist Dr. Frank Caprio wrote, "There is a tendency among some lesbians to react to various situations in a sadistic manner. … Suicides among them reflect their sadomasochism" (Caprio, 1954, p. 173-4). One of Caprio's patients had a lover "… who was morbidly jealous and threatened to commit suicide unless she promised to remain forever faithful" (Caprio, 1954, p. 173). In a 1969 case history Dr. Leon Wallace's male homosexual patient contemplated suicide. His state of loneliness and hopelessness stemmed from the "… inability to develop a lasting and satisfying homosexual relationship, and he was ready to kill himself rather than go on living in this lonely way" (Wallace, 1969, p. 349).

A male homosexual identified as Weber told Dr. David Gottlieb that most of gay sexuality was a substitute for loneliness – a type of addiction. Weber revealed, "There are homosexuals who make a full-time business out of sex. They're often very attractive people. Many are on the verge

of suicide or have made several attempts. … It does lead to complete depression" (Gottlieb, 1977, p. 128). Psychiatrist Dr. Charles Socarides believed that the higher rates of suicide for LGB youth was "… not because of anything society has done to them, but because they are desolate over their homosexual inclinations" (Socarides, 1995, p. 294). Given this clinical evidence the best way to lower LGBTQ suicide rates is to help youth identify with their biological gender and their corresponding masculinity or femininity.

A transsexual identity or a homosexual orientation is not fixed when a child enters grade school. A hundred years of clinical science has consistently shown that homosexuality and gender dysphoria develop along multiple environmental paths that usually feature trauma and rejection (Freud, 1905/1949; Ferenczi, 1916; Stekel 1921/1946; Rado, 1940; Kardiner, 1954; Hadden, 1968, Barnhouse, 1977, Tyson, 1982, Nicolosi 1991, Nicolosi 2009). Dr. Ruth Tiffany Barnhouse stated, "It is unscientific as well as unethical to consider homosexuality as a settled diagnosis for anyone under the age of at least twenty-one" (Barnhouse, 1977, p. 61).

Even in adolescence and adulthood many transsexuals have learned to embrace their biological gender and many homosexuals have changed their sexual orientation to heterosexual (Stekel & Frohman, 1930; Henry, 1937; Freud, A., 1950; Lagache, 1950; Poe, 1952; Caprio, 1954; West, 1955; Eidelberg, 1956; Bergler, 1956; Allen, 1958, Glover, 1960; Bieber et al., 1962; Ellis, 1965; Mintz, 1966; Singer & Fischer, 1967; Kaye et al., 1967; Greenson, 1968; Jacobi, 1969; Wallace, 1969; Hatterer, 1970; Barnhouse, 1977; Socarides, 1978; Stoller, 1978; Kronemeyer, 1980; Blackman, 2002). Dr. Robert J. Stoller reported, "Our group, concentrating on very feminine boys (those we think are transsexuals, not necessarily those who will become 'merely' homosexuals), has regularly been able to diminish or remove that behavior" (Stoller, 1978, p. 554). With these facts in mind a sexually confused student should not be directed to an LGBTQ adult or organization that will indoctrinate them by affirming their confused psychological state.

To not tell a sexually confused student their best option is to affirm their biological gender and develop a healthy heterosexual orientation is deceptive advice and deprives the student of choice. Michigan schools should help as many sexually confused students as possible to overcome a gender identity disorder or homosexual attractions. This does not happen through gay affirming organizations such as Gay-Straight Alliances. The SBE needs to serve the best interests of all students, as well as sexually confused students, even though those interests *run counter to LGBTQ political interests.*

The other major flaw in the SBE's LGBTQ statement and guidance proposal is that it disregards the civil right of same gender privacy. Same gender privacy in public bathrooms and locker rooms has been a tacit civil right. It has not been stated explicitly as a civil right because it has been so universally understood. Only LGBTQ political interests put the interests of gender identity disorders over the civil right of same gender privacy.

The civil right of same gender bathroom and locker room privacy dictates that males are not allowed in female bathrooms or locker rooms and females are not allowed in male bathrooms or locker rooms. A male is not a female because he wants to be one and a female is not male because she wants to be one. Male and females are given privacy in public bathrooms and locker rooms according to biological and anatomical differences, period.

The SBE has carried the LGBTQ political interests to their logical extreme, even proposing to let students participate in sports according to their gender identity instead of their biological sex. It is an absurd proposal, supporting the delusions of the LGBTQ culture over the interests of fairness and common sense.

In conclusion, I recommend that the SBE rework the LGBTQ guidance proposal with the interests of all students at the forefront as well as the civil right of same gender privacy that has been and is an expectation of our culture. Please look at all the evidence and data. Be advised that historically, LGBTQ advocates do not promote the best interests of the individual student; they promote the best interests of the LGBTQ political movement. The evidence that LGBTQ advocates argue against is the evidence most in need of evaluation for the interests of the health and safety of our students.

References:

Allen, C. (1958). *Homosexuality – Its Nature, Causation and Treatment*. London, England: Staples Press.

American College of Pediatricians (2016). Gender Ideology Harms Children. http://www.acpeds.org/the-college-speaks/position-statements/gender-ideology-harms-children

Bakwin, H. (1968). Deviant Gender-Role Behavior in Children: Relation to Homosexuality. *Pediatrics*, *41*(3), 620-629.

Barnhouse, R. T. (1977). *Homosexuality: A Symbolic Confusion,* New York, NY: Seabury Press.

Bayer, R. (1981), *Homosexuality and American Psychiatry.* New York: Basic Books.

Bene, E. (1965). On the genesis of male homosexuality: An attempt at clarifying the role of parents. *British Journal of Psychiatry, 111*, 803-813.

Bergler, E. (1956). *Homosexuality: Disease or way of life.* New York, NY: Hill and Wang.

Bieber, I. (1967a). Sexual deviations. II: Homosexuality. In A. M. Freedman and H. I. Kaplan (EDs.), *Comprehensive Textbook of Psychiatry* (pp. 963-976). Baltimore, MD: The Williams & Wilkins Company.

Bieber, I., Dain, H., Dince, P., Drellich, M., Grand, H., Gundlach, R., Kremer, M. Rifkin, Wilber, C., and Bieber, T. (1962). *Homosexuality: A Psychoanalytic Study of Male Homosexuals.* New York, NY: Basic Books.

Blackman, J. S. (2002). Shift from homosexual to heterosexual orientation during the termination phase of analysis. In C. W. Socarides & A. Freedman (Eds.), *Objects of Desire – The Sexual Deviations,* Madison, CT: International Universities Press, 41-70.

Brown, D. G. (1957). The development of sex-role inversion and homosexuality. *Journal of Pediatrics, 50*, 613-619.

Caprio, F. S. (1954). *Female Homosexuality – A Psychodynamic Study of Lesbianism*. New York, NY: The Citadel Press.

Centers for Disease Control and Prevention (2015). HIV Among Gay and Bisexual Men. http://www.cdc.gov/hiv/group/msm/index.html

Centers for Disease Control and Prevention (2015). STDs in Men Who Have Sex with Men. http://www.cdc.gov/std/stats14/msm.htm

Eidelberg, L. (1956). Analysis of a case of a male homosexual. In Lorand, S. & Balint, M. (eds.), *Perversions, psychodynamics and therapy*. New York, NY, Random House, 279-289.

Ellis, A. (1965). *Homosexuality: Its Causes and Cure*. New York, NY: Lyle Stuart.

Ferenczi, S. (1916). *Contributions to Psycho-Analysis* (E. Jones, Trans.). Boston, MA: Richard G. Badger.

Freud, S. (1949). *Three essays on the theory of sexuality* (J. Strachey, Trans.). London, England: Imago Publishing Company. (Translated from Freud's final revision published 1942; original work published 1905).

Freud, A. (1950). Homosexuality. Unpublished presentation given to the New York Psychoanalytic Society on April 17, 1950. Courtesy of the A. A. Brill Library in New York City.

Gershman, H. (1975). The effect of group therapy on compulsive homosexuality in men and women. *American Journal of Psychoanalysis*, 35(4), pp. 303-312.

Glover, E. (1960). *The Roots of Crime*. New York, NY: International Universities Press.

Gottlieb, D. (1977). *The Gay Tapes – A Candid Discussion About Male Homosexuality*. New York, NY: Stein & Day.

Greenson, R. (1968). Disidentifying from mother; its special importance for the boy. *International Journal of Psychoanalysis, 49*, 370-374.

Hadden, S. B. (1968). Group psychotherapy for sexual maladjustments. *American Journal of Psychiatry. 125*(3), 327-332.

Hatterer, L. (1970). *Changing Homosexuality in the Male: Treatment for Men Troubled by Homosexuality*. New York, NY: McGraw-Hill Book Company.

Henry, G. W. (1937). Psychogenic factors in overt homosexuality. *The American Journal of Psychiatry, 93*(4), 889-908.

Jacobi, J. (1969). A case of homosexuality. *The Journal of Analytical Psychology. 14*, 48-64.

Karpman, B. *The Sexual Offender and His Offenses – Etiology, Pathology, Psychodynamics and Treatment*. New York, NY: Julian Press.

Kaye, H. E., Bert, S., Clare, J., Eleston, M. R., Gershwin, B. S., Gershwin, P., Kogan, L. S., Torda, C., & Wilber, C. B. (1967). Homosexuality in women. *Archives of General Psychiatry, 17*, 626-634.

Kinsey, A., W. Pomeroy and C. Martin, (1948). *Sexual Behavior in the Human Male*. Philadelphia, PA: W. B. Saunders Company.

Lagache, D. (1950). Homosexuality and jealousy. *The International Journal of Psycho-Analysis, 31,* 24-31.

Kardiner, A. (1954). *Sex and Morality*. Indianapolis, IN: The Bobbs-Merrill Company.

Kronemeyer, R. (1980). *Overcoming Homosexuality*. New York, NY: Macmillan.

Marmor, J. (1965). *Sexual Inversion*. New York, NY: Basic Books.

McDougall, J. (2000). Sexuality and the neosexual. *Modern Psychoanalysis, 25*(2), 155-165.

Merriam-Webster (2016). Dictionary. http://www.merriam-webster.com/dictionary/bigot

Michigan Department of Education (2015). Top 10 in 10 Years. https://www.michigan.gov/documents/mde/10in10_FINAL_507948_7.pdf?20151209104351

Mintz, E. E. (1966). Overt male homosexuals in continued group and individual treatment. *Journal of Consulting Psychology, 30*(3), 193-198..

Nicolosi, J. (1991). *Reparative Therapy of Male Homosexuality – A New Clinical Approach*. Lanham, MD: Rowman & Littlefield Publishers.

Nicolosi, J. (2009). *Shame and Attachment Loss – The Practical Work of Reparative Therapy*. Downer's Grove, IL: InterVarsity Press.

Nicolosi, J. & Nicolosi, L. A. (2002). *A Parent's Guide to Preventing Homosexuality*. Downer's Grove, IL: InterVarsity Press.

Poe, J. S. (1952). The successful treatment of a 40 year old passive homosexual based on an adaptational view of sexual behavior. *Psychoanalytic Review. 39,* 23-33.

Rado, S. (1940). A critical examination of the concept of bisexuality. *Psychosomatic Medicine, 2*(4), 459-467.

Shearer, M. (1966). Homosexuality and the pediatrician; early recognition and preventation counseling. *Clinical Pediatrics, 5,* 514-518.

Singer, M. and Fischer, R. (1967). Group psychotherapy of male homosexuals by a male and female co-therapy team. *International Journal of Group Psychotherapy, 17*(1), 44-52.

Socarides, C. (1975). *Beyond Sexual Freedom*. New York, NY: Quadrangle Books.

Socarides, C. (1978), *Homosexuality.* New York, NY: Jason Aronson.

Socarides, C. (1995). *Homosexuality A Freedom Too Far*. Phoenix, AZ: Adam Margrave Books.

Stekel W. (1946). *The Homosexual Neurosis* (J. S. V. Teslaar, Trans.). New York, NY: Emerson Books. (Original work published in 1921: *Onanie und Homosexualität – Die Homosexuelle Neurose*. Berlin, Germany: Urban & Schwarzenberg)

Stekel, W. and Frohman, B. S. (1930). Is homosexuality curable? *The Psychoanalytic Review*, *17*, 443-451.

Stoller, R. (1978). Boyhood gender aberrations: treatment issues. *Journal of the American Psychoanalytic Association*, *26*, 541-558.

Tyson, P. (1982). A developmental line of gender identity, gender role, and choice of love object. *Journal of the American Psychoanalytic Association, 30*, 61-86.

Wallace, L. (1969). Psychotherapy of a male homosexual. *Psychoanalytic Review 56*(3) 346-364.

West, D. J. (1955). *The Other Man – A Study of the Social, Legal, and Clinical Aspects of Homosexuality*. New York, NY: Whiteside.

West, D. J. (1959). Parental figures in the genesis of male homosexuality. *International Journal of Social Psychiatry*, *5*, 85-97.