Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

Substance Abuse and Mental Health Services Administration
SAMHSA

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Acknowledgements

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

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Recommended Citation
Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

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Contents

Executive Summary

Lesbian, gay, bisexual, and *transgender* youth, and those who are *questioning* their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's LGBTQ identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority*[1] youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[2]—is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender[3] sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood

(Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

Therapeutic Efforts with Sexual and Gender Minority Youth[4]

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

Ending the Use of Conversion Therapy for Minors

Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

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Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[5]—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

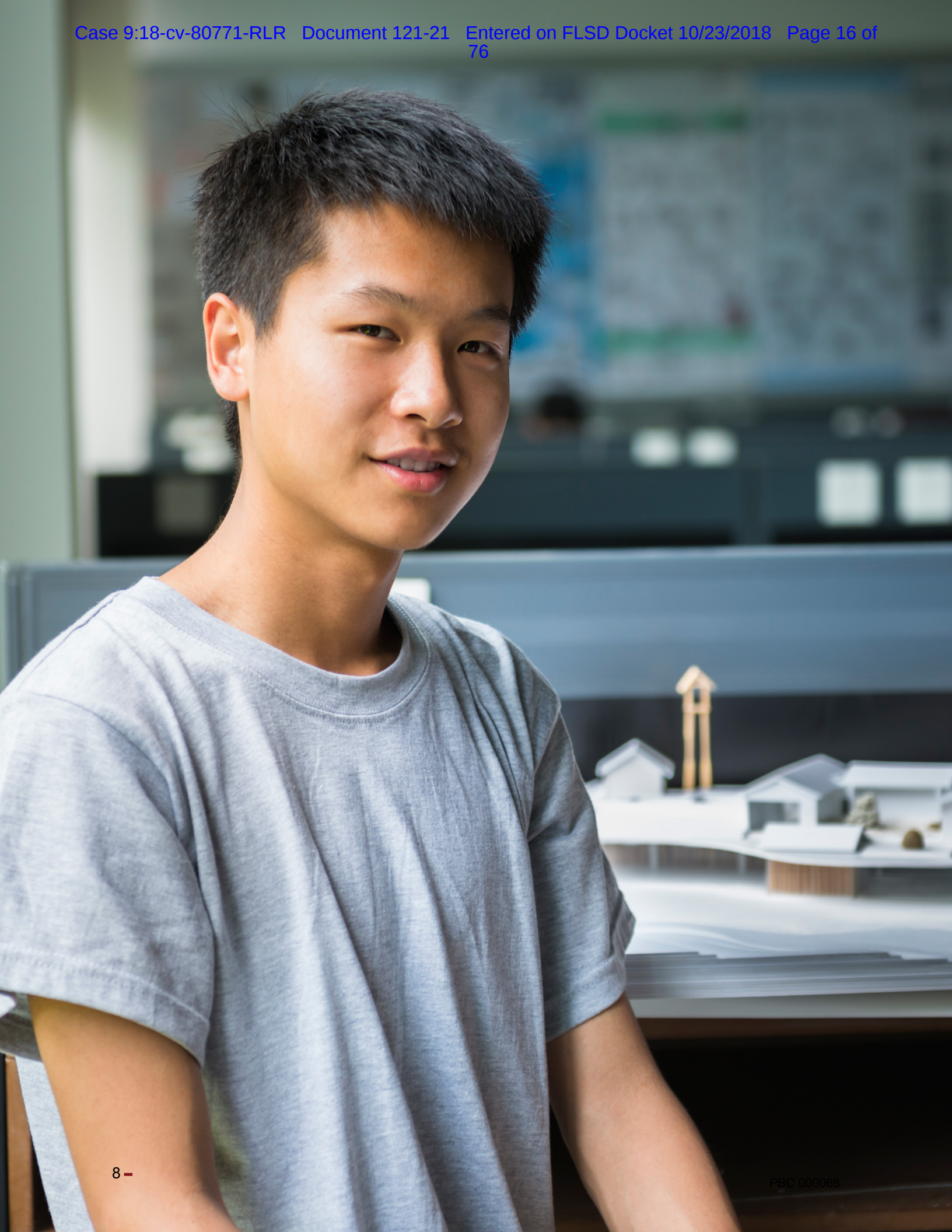
This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights areas of opportunity for future research, and provides an overview of mechanisms to eliminate the use of harmful therapies. In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: *Family and Community Acceptance*, *School-Based Issues*, *Pediatric Considerations*, and *Affirmative Exploratory Therap* . In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

> "Being gay is not a disorder. Being transgender is not a malady that requires a cure."
>
> **—Vice Admiral Vivek H. Murthy, 19th U.S. Surgeon General**

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population

SAMHSA's mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.[6]As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.



Professional Consensus Process

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would consitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.


“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”
Sue Thau

Statements of Professional Consensus

The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals' work in this area.

Guiding Principles

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of "self-determination" requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of "justice" and "beneficence and nonmaleficence" require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional Consensus on Conversion Therapy with Minors

1. Same-gender[7]sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.
5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in pre-pubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics[8], and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

    Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

Research Overview

Sexual Orientation

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalytic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)[9].

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth[10]. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression[11](American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned as birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder[12](APA Task Force on Gender Identity and Gender Variance, 2009). Though there

have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories[13]: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014). Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)[14]. Compared to earlier cohorts, today's sexual minority adolescents are developing an awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or "coming out" as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

Clinical Issues in Adolescence

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)[15]. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing

not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar,

2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities –may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity. Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school

from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the over-representation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore,

important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, & Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction[16]

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment[17]:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to

change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting & Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria

(Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families[18]

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding**.** A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health

and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-appropriate milestones and facilitiating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and lives of *lesbian*, *gay*, *bisexual*, *transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader principles and

concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This is includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further, behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual

and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone

therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disclipinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescents' gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal

of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults, withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mammoplasty beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

Future Directions for Research

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identify among youth.

Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.
- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and

how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, stating in part:

> *"When assessing the validity of conversion therapy, or other practices that seek to change an individual's gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.*
>
> *As part of our dedication to protecting America's youth, this Administration supports efforts to ban the use of conversion therapy for minors."* (Jarrett, 2015)

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“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”
Sue Thau

Approaches to Ending the Use of Conversion Therapy

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
    - Adoption of public policies that end discrimination
    - Increasing access to health care
    - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
    - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
    - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
    - Inclusion of affirmative information and treatment models in professional training curriculum
    - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts
    - State and federal legislation that bans sexual orientation and gender identity change efforts
    - Federal and state regulatory actions and additional Administration activities
    - Legal action

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,[19]including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the “Don’t Ask, Don’t’ Tell” policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;
- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the “It Gets Better” Project, which aims to gives LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more

accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.[20]

Dissemination of information, training and education for behavioral health providers

The major health associations have issued policy statements critical of conversion therapy including the World Health Organization, the American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, American Counseling Association, American Psychoanalytic Association, and the National Association of Social Workers, among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.[21]

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*. As part of this publication, the association indicates that "doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by […] identifying various harmful practices (e.g., historical practice of using 'reparative' therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients."

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.

Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of "*Do No Harm*" through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people's dignity.

Legislative, regulatory, and legal efforts

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.
- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.[23]

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."[24]

Guidance for Families, Providers, and Educators

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*). Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

Promoting Family and Community Acceptance and Support

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of "connectedness" has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

Key Points:

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent's sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child's gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child's overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.
- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child's sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent's identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child "fit in," have a good life and be accepted by others. The Family Acceptance Project's research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family's cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual's dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child's risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don't have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child's well-being - without "accepting" an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child's experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child's safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

Resources

Family Acceptance Project: http://familyproject.sfsu.edu/

Gender Spectrum: www.genderspectrum.org

Institute for the Study of Sexual Identity: www.sexualidentityinstitute.org

PFLAG : www.pflag.org

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Bullying, Harassment, and Other School-Based Issues

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise

mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.
- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH): www.cdc.gov/HealthyYouth/

GLSEN: www.glsen.org

Human Rights Campaign, Welcoming Schools Initiative: www.welcomingschools.org

National Center for Lesbian Rights, Youth Project: www.nclrights.org/our-work/youth

National Association for School Psychologists, Committee on GLBTQ Issues: www.nasponline.org/advocacy/glb.apsx

PFLAG : www.pflag.org

Safe & Supportive Schools Project: http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx

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> “When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl’s clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression. Thankfully, one of my friends recognized the warning signs and called social services, which intervened and got me the housing and medical care I needed. It is always darkest before the dawn, but I’m living proof that a smart bystander can save a life.”
>
> **—Amy**

Pediatric Care Considerations for LGBTQ Children and Adolescents

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.
- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics, 132*(1), 198 -203 doi: 10.1542/peds.2013-1282

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> “Having my family reject me because I’m trans broke my heart into more pieces than I could have imagined. Even more painful was the feeling they no longer loved or valued me. Having my Grandmother take me in restored my belief in love. To have her arms to fall into meant that I no longer was alone, that death did not seem like the only road to stablility, comfort, and joy. That perhaps I should build a future because I again had someone to help me do so and enjoy it with me.”
>
> **—Malachi**

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Affirmative Care for Gender Minority Youth

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child’s developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Here are a few key points to keep in mind when considering a supportive and balanced approach for transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender non-conforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy **and** a psychological/readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.
- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or inexplicitly make an adolescent feel “stuck” in a gender identity.
- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.

- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider's input is valued and perceived as equally critical to the care of the individual patients served.

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

PFLAG Transgender Network: http://community.pflag.org/transgender

Gender Spectrum: www.genderspectrum.org

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Hidalgo et al., 2013. The gender affirmative model: What we know and what we aim to learn. *Human Development*, *56*, 285-290.

> "During my senior year of high school, my English teacher would sit with me every day after school and listen as I told him how confused I was over my sexuality. He was one of the very few I told about being in conversion therapy. He told me that I had to listen to my heart and follow it, and not to try and force any specific outcome. He was the only person in my life at the time who gave me any assurance that I was going to make it through this."
>
> **—Mathew**

Summary and Conclusion

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

> "It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life."
>
> **—Sam**

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Appendix A: Glossary of Terms

Cisgender: A person whose gender identity, gender expression, and sex assigned at birth all align.

Conversion therapy: Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

Gender dysphoria: Psychological distress due to the incongruence between one's body and gender identity.

Gender expression: The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

Gender identity: A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

Gender nonconforming, gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender a birth which may or may not differ from their gender identity later in life.

Questioning: Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring ones sexual orientation and/or gender identity.

Sex assigned at birth: The sex designation given to an individual at birth.

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

Transgender: A person who feels that their gender identity does not match their physical body and differs from the gender that others observed and gave them at birth (assigned or birth gender).

Transition: A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

Appendix B: Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

The lead scientific writer for this report was Laura Jadwin-Cakmak, MPH with support from W. Alexander Orr, MPH as the Task Lead from Abt Associates.

The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, Director LGBT Office) and Judith Glassgold, PsyD (Associate Executive Director, Government Relations, Public Interest Directorate).

The Expert Panel consisted of a panel of researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel included experts with a background in family therapy and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark A. Yarhouse, PsyD.

Endnotes

1. The term "sexual and gender minority" is an umbrella term. "Sexual minority" refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. "Gender minority" refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term "same-gender" (as opposed to "same-sex") is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term "sexual and gender minority" is an umbrella term. "Sexual minority" refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. "Gender minority" refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, particularly common when youth are the population of focus.
7. To be inclusive of transgender populations, the term "same-gender" (as opposed to "same-sex") is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that "sexual orientation by itself is not to be considered a disorder." Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD (Cochran, S. D., Drescher, J., Kismödi, Giami, García-Moreno, Atalla, …, & Reed, 2014).
10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one's assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.

12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term "gender dysphoria" (lowercase) is used to broadly describe the discomfort or distress caused by the discrepancy between a person's gender identity and that person's sex assigned at birth and/or primary or secondary sex characteristics. We will use the term "individuals with gender dysphoria" throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.
13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.
16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources Strengthening Protection against Discrimination.
20. For example, "A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children" http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS. Another helpful resources is "Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children" http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.
21. See for instance, American Psychological Association (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.
22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at https://www.aamc.org/download/414172/data/lgbt.pdf.
23. Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf.

Substance Abuse and Mental Health Services Administration

SAMHSA

HHS Publication No. (SMA) 15-4928

Annals of Internal Medicine POSITION PAPER

Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians

Hilary Daniel, BS, and Renee Butkus, BA, for the Health and Public Policy Committee of the American College of Physicians*

In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. These recommendations include enhancing physician understanding of how to provide culturally and clinically competent care for LGBT individuals, addressing environmental and social factors that can affect their mental and physical well-being, and supporting further research into understanding their unique health needs.

Ann Intern Med. 2015;163:135-137. doi:10.7326/M14-2482 **www.annals.org**
For author affiliations, see end of text.
This article was published online first at www.annals.org on 12 May 2015.

The lesbian, gay, bisexual, and transgender (LGBT) community is diverse, comprising persons from various races, ethnicities, and socioeconomic backgrounds; however, LGBT persons face a common set of challenges within the health care system. These challenges range from access to health care coverage and culturally competent care to state and federal policies that reinforce social stigma, marginalization, or discrimination. Recent years have brought about reliable data collection, research, and a greater understanding of the health care needs of the LGBT community and the challenges they face in accessing care. Although great strides have been taken in reducing health disparities in the LGBT community, much more needs to be done to achieve equity for LGBT persons in the health care system.

Although members of the LGBT community face similar health concerns as the general population, certain disparities are reported at a higher rate among LGBT persons than the heterosexual population (1). These disparities experienced by LGBT persons may be compounded if they are also part of a racial or ethnic minority (1). Of note, LGBT persons are more likely to identify themselves as being in poor health than heterosexual individuals, and different segments of the LGBT population have individual health risks and needs. For example, gay and bisexual men are at increased risk for certain sexually transmitted infections and account for more than half of all persons living with HIV or AIDS in the United States (1); lesbian women are less likely to have mammography or Papanicolaou test screening for cancer (2); lesbian and bisexual women are more likely to be overweight or obese (3); and lesbian, gay, and bisexual persons are more likely to become disabled at a younger age than heterosexual individuals (4).

Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on transgender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7).

Addressing these disparities will require changes in the way LGBT persons and their families are regarded in society and by the health care system. Policies that are discriminatory toward the LGBT community, or are no longer supported by empirical research, continue to reinforce the environmental and social factors that can affect the mental and physical well-being of LGBT persons. The American College of Physicians (ACP) has a long-standing commitment to improving the health of all Americans and opposes any form of discrimination in the delivery of health care services. ACP is dedicated to eliminating disparities in the quality of or access to health care and is committed to working toward fully understanding the unique needs of the LGBT community and eliminating health disparities for LGBT persons.

This Executive Summary provides a synopsis of the full position paper, which is available in **Appendix** (available at www.annals.org).

Methods

The ACP Health and Public Policy Committee, which is charged with addressing issues affecting the

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health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed numerous studies, reports, and surveys on LGBT health care and related health policy. The committee also reviewed information on how state and federal policies may affect the physical and mental health of the LGBT population. Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 27 April 2015.

ACP Position Statements and Recommendations

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (**Appendix**).

A glossary of LGBT terminology used throughout this paper can be found at https://lgbt.ucsf.edu/glossary-terms.

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Conclusion

The ACP recognizes that reducing health disparities in the LGBT population will take concerted efforts not only by those in the medical community but also from society as a whole. Training future physicians to be culturally and clinically competent in LGBT health care, working with practicing physicians to increase their understanding of the LGBT population and their health needs, advocating for practical health policies supported by empirical research, and working to eliminate laws that discriminate against the LGBT community and their families are all important steps to reducing and ultimately eliminating the health disparities experienced by the LGBT community.

Note Added in Proof: On 12 May 2015, the U.S. Food and Drug Administration released the document "Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products: Draft Guidance for Industry." The proposed recommendations would replace the lifetime ban on blood donation by men who have sex with men with a 12-month deferral period from most recent sexual contact.

From the American College of Physicians, Washington, DC.

Disclaimer: The authors of this article are responsible for its contents, including any clinical or treatment recommendations.

* This paper, written by Hilary Daniel, BS, and Renee Butkus, BA, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee from initiation of the project until its approval and authored this position paper are Thomas G. Tape, MD (*Chair*); Douglas M. DeLong, MD (*Vice-Chair*); Micah W. Beachy, DO; Sue S. Bornstein, MD; James F. Bush, MD; Tracey Henry, MD; Gregory A. Hood, MD; Gregory C. Kane, MD; Robert H. Lohr, MD; Ashley Minaei; Darilyn V. Moyer, MD; and Shakaib U. Rehman, MD. Approved by the ACP Board of Regents on 27 April 2015.

Acknowledgment: Additional contributions provided by Jorge Ramallo, MD.

Financial Support: Financial support for the development of this guideline comes exclusively from the ACP operating budget.

Disclosures: Dr. Moyer is the elected Chair of the ACP Board of Governors. Authors not named here have disclosed no conflicts of interest. Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M14-2482.

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Annals of Internal Medicine

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Appendix: Lesbian, Gay, Bisexual, and Transgender Health Disparities: A Policy Position Paper From The American College of Physicians

Understanding the LGBT Community

The LGBT community is a highly diverse and multifaceted group of persons encompassing all cultures, ethnicities, and walks of life. Under the LGBT umbrella, each individual group faces unique cultural and health-related needs but shares common challenges, such as social stigma, discrimination, and disparities in health care, that unite them.

Research into LGBT health has been expanding as the community has become more visible and outspoken about engaging the health care system in developing a knowledge base on the distinctive challenges and health disparities they face. However, gaps in the medical community's understanding of the overall makeup of the LGBT community and the environmental and social factors that may influence the needs of those persons present an obstacle to addressing challenges in a meaningful way. In 2011, the Institute of Medicine issued a report outlining a research agenda targeting several areas that could affect how the health care system approaches LGBT health, including demographics, social influences, disparities and inequalities, intervention that includes increasing access to care and addressing physical or mental conditions, and transgender-specific needs. The report also recommended the inclusion of the LGBT community in national health surveys and emphasized a need for scientific rigor and a respectful environment when gathering data (8).

One important obstacle to identifying health issues within the LGBT population is a lack of reliable data and the exclusion of sexual and gender minorities' identification on federal health surveys. Recent efforts have been made to gather population data on persons who identify as lesbian, gay, bisexual, or transgender and those who identify as being in a same-sex marriage or partnership. For the first time in 2010, the U.S. Census Bureau did not change the data reporting the number of same-sex couples that identified as being married. Before that, the 2000 U.S. Census changed the relationship status of same-sex partners identifying as being the spouse of the head of household to an "unmarried partner" because there were no states in which same-sex marriage was legal. In the 1990 U.S. Census, if a same-sex couple identified themselves as married, the sex of 1 of the respondents was automatically changed to the opposite sex and the couple was enumerated as an opposite-sex married couple (9). The Patient Protection and Affordable Care Act allows the Department of Health and Human Services (HHS) to collect "additional demographic data to further improve our understanding of health disparities," and in 2013, the National Health Interview Survey–an annual study of health care access, use, and behaviors–included sexual orientation as part of its data collection system (10). Recent estimates put the number of persons who identify as lesbian, gay, bisexual, or transgender at more than 9 million or approximately 3.4% of the U.S. population, which some analysts believe may be an underestimate (1). Individuals who may have same-sex attractions or experiences but do not self-identify as LGBT may still fall into the category of sexual minorities and face health disparities associated with LGBT persons.

Access to Care in the LGBT Population

The LGBT community has often been overlooked when discussing health care disparities and continues to face barriers to equitable care. Barriers to care are multidimensional and include stigma and discrimination, poverty, lack of education, racial or ethnic minority status, and other psychological health determinants (11). Studies show that persons who identify as LGBT have greater economic disadvantages and are more vulnerable to poverty than those who do not. Using available information from national surveys, the Williams Institute reports higher overall poverty rates for persons identifying under the LGBT umbrella than heterosexual persons and higher rates of poverty in same-sex couples than heterosexual couples (7.6% vs. 5.7%) (12).

Research shows that LGBT adults and their children are more likely to be uninsured by public or private insurance and that they and their family members continue to face difficulties in gaining access to care and face a higher risk for health disparities than the general population (2). Most Americans gain health insurance coverage through their employer; data are limited but suggest LGBT persons face higher unemployment rates

than non-LGBT persons. A 2009 survey in California found a 14% unemployment rate among LGBT adult workers compared with 10% among non-LGBT adults (13).

The Affordable Care Act sought to increase access to care for low-income Americans by expanding Medicaid programs to all persons at or below 133% of the federal poverty level, providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state marketplace exchanges, and including nondiscrimination protections in health plans sold on the exchanges. Although estimates suggested that the number of uninsured LGBT persons would be reduced as a result of Medicaid expansion, only about half of states have chosen to expand their Medicaid programs, which greatly diminishes its effect. This increases the number of LGBT persons who may fall into what has been dubbed the "coverage gap," in which persons may earn too much to qualify for their state's Medicaid program but too little to qualify for subsidies (14).

Transgender individuals face additional challenges in gaining access to care. Not only are they more likely to be uninsured than the general population, they are more likely to be uninsured than lesbian, gay, or bisexual persons (1). They also face high out-of-pocket costs for transgender-specific medical care if they lack insurance or their insurance coverage does not cover transgender health care. According to the American Congress of Obstetricians and Gynecologists, transgender youth who receive inadequate treatment are at an increased risk for engaging in self-mutilation or using illicit venues to obtain certain treatments; research shows more than 50% of persons who identify as transgender have obtained injected hormones through illegal means or outside of the traditional medical setting (6).

Mental and Physical Health Disparities

Existing research into the health of the LGBT population has found some health disparities that disproportionately affect the LGBT population. In 2000, the first federally funded research study on the health of LGBT persons assessed 5 major areas of concern for lesbian, gay, and bisexual persons (the report noted that transgender health concerns warranted an independent evaluation): cancer, family planning, HIV and AIDS, immunization and infectious diseases, and mental health (15). Research has shown that lesbian women are less likely to get preventive cancer screenings; lesbian and bisexual women are more likely to be overweight or obese (16); gay men are at higher risk for HIV and other sexually transmitted infections; and LGBT populations have the highest rates of tobacco, alcohol, and other drug use (17). Lesbian, gay, and bisexual persons are approximately 2.5 times more likely to have a mental health disorder than heterosexual men and women (18).

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons (19). A 2011 survey of transgender or gender-nonconforming persons found that 41% reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (20).

Positions

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

Nondiscrimination policies are in place to prevent employment discrimination or harassment based on race, color, national or ethnic origin, age, religion, sex, disability, genetics, or other characteristics protected under federal, state, or local law (21). However, state law varies considerably on the inclusion of sexual orientation and gender identity in nondiscrimination policies and some policies based on sexual orientation alone may not include gender identity. Eighteen states have employment nondiscrimination or equal employment opportunity statutes that cover both gender identity and sexual orientation, and an additional 3 states have nondiscrimination statutes that cover sexual orientation only (22). The Human Rights Campaign, an LGBT rights organization, estimated that as a result of these assorted laws, 3 of 5 U.S. citizens live in an area that does not provide protection for gender identity or sexual orientation (23).

Sexual orientation and gender identity are inherently different and should be considered as such when assessing whether nondiscrimination or harassment policies provide protection to all members of the LGBT community. According to the Institute of Medicine, "sexual orientation" refers to a person's enduring pattern of or disposition to have sexual or romantic desires for, and relationships with, persons of the same sex or both sexes (8). "Gender identity" refers to a person's basic sense of being a man or boy, a woman or girl, or another gender. Gender identity may or may not correspond to a person's anatomical sex assigned at birth. The term "transgender" is now widely used to refer to a diverse group of persons who depart significantly from traditional gender norms (24). Persons who have a "marked difference" between their anatomical sex at birth and their expressed or experienced gender may

be diagnosed with gender dysphoria, which is a diagnosis under the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (25).

Evidence shows that individuals with gender identity variants face increased discrimination, threats of violence, and stigma. The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a national survey of transgender and gender-nonidentifying persons and found high rates of harassment (78%), physical assault (35%), and sexual violence (12%) (20). More than 90% of survey participants reported harassment or discrimination in the workplace, and they experience double the rate of unemployment than the general population (20). Therefore, LGBT persons are more likely to lose their job or not be hired (26).

Employers have the option to include gender identity as part of their company's nondiscrimination or antiharassment policies even if their state does not, and many companies have chosen to include comprehensive protections policies. To reduce the potential for discrimination, harassment, and physical and emotional harm toward persons who are not covered by current protections, the medical community should include both sexual orientation and gender identity as part of any comprehensive nondiscrimination or antiharassment policy.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

The LGBT community is at increased risk for physical and emotional harm resulting from discrimination or harassment, and transgender persons may face greater inequalities in the health care system than the general population. Of note, 19% of transgender persons lack any type of health insurance (20). A handful of states have laws about insurance coverage for transgender health care, such as hormone replacement therapy or sexual reassignment surgery, which may be considered medically necessary as part of the patient's care. Eight states and the District of Columbia have prohibitions on insurance exclusion of treatments for sex reassignment surgery (27).

The World Professional Association for Transgender Health has developed health care standards for transgender persons who have been diagnosed with gender dysphoria. The standards emphasize treatments that will achieve "lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" and may or may not include modification to a person's gender expression or how this individual appears or presents physically to others (28). Research shows that when transgender persons receive individual, medically appropriate care, they have improved mental health, reduction in suicide rates, and lower health care costs overall because of fewer mental health–related and substance abuse–related costs (29). However, not all health plans cover all services associated with transgender health or consider such services medically necessary; some plans may issue blanket exclusions on transgender health care, not cover certain services for a transgender person as they would for nontransgender persons, or only cover the cost of gender reassignment surgery if certain conditions are met. For example, an insurance company may cover posthysterectomy estrogenic hormone replacement therapy for biological women but will not cover a similar type of hormone therapy for a postoperative male-to-female transgender patient. Many professional medical organizations, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Congress of Obstetricians and Gynecologists, and American Academy of Family Physicians, consider gender transition–related medical services medically necessary (30).

The decision to institute a hormone therapy regimen or pursue sexual reassignment surgery for transgender individuals is not taken lightly. Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs. Throughout the course of treatment, patients and their physicians or health care team should discuss available options and the evidence base for those treatments in which such evidence exists. It is especially important that transgender patients whose health care team has determined that treatment should include cross-sex hormone therapy or sexual reassignment surgery and postoperative hormone therapy be well-informed about the potential health risks associated with the long-term use of some hormonal replacement therapies before treatment.

Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive. The most extensive and expensive sexual reassignment surgeries may cost tens of thousands of dollars; this does not include associated costs, such as counseling, hormone replacement therapy, copays, or aftercare. The high costs of treatment can result in persons who cannot access the type of care they need, which can increase their levels of stress and discomfort and lead to more serious health conditions. In 2014, the HHS lifted the blanket ban on Medicare coverage for gender reassignment surgery (31) and the federal government announced it would no longer prohibit health plans offered on the Federal Employees Health Benefits Program from offering gender reassignment

as part of the plan (27). Transgender health advocates are hopeful this will result in wider coverage for transgender care in private health plans.

The cost of including transgender health care in employee health benefits plans is minimal and is unlikely to raise costs significantly, if at all. A survey of employers offering transition-related health care in their health benefit plans found that two thirds of employers that provided information on actual costs of employee utilization of transition-related coverage reported 0 costs (32). This is the result of a very small portion of the population identifying as transgender and a smaller portion of that group having the most expensive type of gender reassignment surgery as part of their treatment. An analysis of the utilization of transgender health services over 6 years after transgender discrimination was prohibited in one California health plan found a utilization rate of 0.062 per 1000 covered persons (33). The inclusion of transgender-related health care services within a health plan may also result in an overall reduction of health care costs over time because patients are less likely to engage in self-destructive behaviors, such alcohol or substance abuse.

3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

The term "family" as it is seen in society is changing and no longer means married heterosexual parents with children. An analysis shows only 22% of families fall into this category (34). Stepparents, single parents, grandparents, same-sex couples, or foster or adoptive parents all make up the changing face of U.S. families. Across the country, LGBT persons are raising children, and demographic data shows that 110 000 same-sex couples are raising as many as 170 000 biological, adopted, or foster children and 37% of LGBT adults have had a child (35). This modern concept of family is no longer dependent on parental status and does not only include adult heads of household with minor children. Same-sex couples and different-sex couples who do not have children may nevertheless have persons in their lives that they consider family.

Despite research that shows a growing trend toward acceptance of LGBT individuals and families (36), there is no widely used standard definition of family inclusive of the diverse nature of the family structure and definitions vary widely: They can differ from state to state, within the Internal Revenue Service for tax purposes, by employers to determine eligibility for health plans, and by hospitals for the purposes of visitation or medical decision making. If LGBT spouses or partners are not legally considered a family member, they are at risk for reduced access to health care and restrictions on caregiving and decision making; further, they are at increased risk for health disparities, and their children may not be eligible for health coverage (34). Therefore, LGBT persons and families may already be at a financial disadvantage, with single LGBT parents 3 times more likely to live near the poverty line than their non-LGBT counterparts and LGBT families twice as likely to live near the poverty threshold (35). These financial disadvantages can translate into lack of access to medical care and poorer health outcomes similar to those experienced by non-LGBT persons and their families who are uninsured or underinsured, in addition to the health disparities that are already reported among the LGBT community.

The Human Rights Campaign's definition of family for health care organizations, developed with multistakeholder input, is inclusive of same- and different-sex married couples and families and is an example of a broad, comprehensive definition of family that includes a person's biological, legal, and chosen family:

> Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. (37)

A definition of family inclusive of all types of families, including the LGBT population, is not only fundamental to reducing the disparities and inequalities that exist within the health care system, but also important for the equal treatment of LGBT patients and their visitors in the hospital setting. Countless accounts show loved ones being denied the right to visit; assist in the medical decision-making process for their partner, minor, or child; or be updated on the condition of a patient because hospital visitation policy broadly prohibits those who are not recognized family members from access to the patient. These policies are discriminatory against LGBT patients, their visitors, and the millions of others who are considered family, such as friends, neighbors, or nonrelative caregivers who can offer support to the patient.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may to act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

When persons or their loved ones need emergency care or extended inpatient stays in the hospital,

they do not often immediately think about access to visitors or hospital visitation policies, the ability to assist in medical decision making, or their legal rights as patients or visitors. Hospital visitation policies are not always clear or consistent about who can visit or make medical decisions for a patient if they become incapacitated or cannot do so themselves. The absence or limited access of loved ones can cause uncertainty and anxiety for the patient. In contrast, the involvement of family and outside support systems can improve health outcomes, such as management of chronic illness and continuity of care (38).

A highly publicized incident of LGBT families facing discrimination and being denied hospital visitation occurred in Florida in 2007. A woman on vacation with her family had an aneurysm and was taken to the hospital. Her same-sex partner and their children were denied the right to see her or receive updates on her condition, and she eventually slipped into a coma and died (39). In response to this incident, President Obama issued a presidential memorandum recommending that the HHS review and update hospital visitation policies for hospitals participating in Medicare or Medicaid and critical-access hospitals to prohibit discrimination based on such factors as sexual orientation or gender identity (40).

Throughout the rulemaking process, the HHS revised the Medicare Conditions of Participation to require that all hospitals explain to all patients their right to choose who may visit during an inpatient stay, including same-sex spouses, domestic partners, and other visitors, and the patients' right to choose a person to act on their behalf. The Joint Commission, the nation's largest organization for hospital accreditation, also updated its standards to include equal visitation for LGBT patients and visitors (41). As a result of these updated policies, most hospitals and long-term care facilities are required to allow equal visitation for LGBT persons and their families.

The presidential memorandum also recommended that the HHS instruct hospitals to disclose to their patients that patients have a right to designate a representative to make medical decisions on their behalf if they cannot make those decisions themselves. The revised Conditions of Participation emphasized that hospitals "should give deference to patients' wishes about their representatives, whether expressed in writing, orally, or through other evidence, unless prohibited by state law" (42). With piecemeal regulations and policies governing the legal rights of LGBT persons and their families, some same-sex spouses or domestic partners choose to prepare advance directives, such as durable powers of attorney and health care proxies, in an effort to ensure their access to family members and their ability to exert their right to medical decision making if necessary.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

The health and financial benefits of marriage for different-sex couples are widely reported, and contemporary research supports similar benefits in same-sex marriage. On the other hand, denial of marriage rights for LGBT persons may lead to mental and physical health problems. Health benefits associated with same-sex marriage result from improved psychological health and a reinforced social environment with community support (43). Research suggests that being in a legally recognized same-sex marriage diminishes mental health differentials between LGBT and heterosexual persons (5). A comparison study on the utilization of public health services by gay and bisexual men before and after Massachusetts legalized same-sex marriage found a reduction in the number of visits for health problems and mental health services. The study noted a 13% reduction in visits overall after the legalization of same-sex marriage (44).

In contrast, denial of such rights can result in ongoing physical and psychological health issues. Thus, LGBT persons encountering negative societal attitudes and discrimination often internalize stressors and have poor health unseen to those around them; further, these stressors can lead to self-destructive behaviors (43). A study of LGBT individuals living in states with a same-sex marriage ban found increases in general anxiety, mood disorders, and alcohol abuse (45). The denial of marriage rights to LGBT persons has also been found to reinforce stigmas of the LGBT population that may undermine health and social factors, which can affect young adults (46). The American Medical Association's broad policy supporting civil rights for LGBT persons acknowledges that denial of civil marriage rights can be harmful to LGBT persons and their families and contribute to ongoing health disparities (47).

Since 2003, the overall support for marriage equality has increased. The shift in attitudes toward acceptance of same-sex marriage has broad positive implications for the future of U.S. civil marriage rights. A 2013 survey by the Pew Research Center revealed that nearly half of U.S. adults expressed support for same-sex marriage. Of note, millennials (those born after 1980) showed the highest rate of support for same-sex marriage rights at 70%. Not only has overall opinion changed, but individually, 1 in 7 respondents reported they had changed their minds from opposing to supporting same-sex marriage. The Pew survey found that 32% of respondents changed their mind because they knew someone who identified as lesbian or gay (36).

The legal landscape is also shifting in favor of inclusive civil marriage rights for same-sex couples. The American Bar Association has adopted a resolution recognizing "that lesbian, gay, bisexual and transgender (LGBT) persons have a human right to be free from discrimination, threats and violence based on their LGBT status and condemns all laws, regulations and rules or practices that discriminate on the basis that an individual is [an] LGBT person" (48). In June 2013, the U.S. Supreme Court struck down a provision of the Defense of Marriage Act that defined marriage as a "union between a man and a woman." The decision allowed legally married same-sex couples to have the same federal benefits offered to heterosexual couples (49). Currently more than half of the states and the District of Columbia allow same-sex marriage, and several states have rulings in favor of same-sex marriage that are stayed pending legal appeals (50). In April 2015, the Supreme Court heard oral arguments in a case involving same-sex marriage bans in Michigan, Ohio, Kentucky, and Tennessee; this will ultimately determine the constitutionality of same-sex marriage bans, including whether states would be required to recognize same-sex marriages performed legally out of state (51).

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

Previous efforts to understand the LGBT population by including sexual orientation or gender identity in health surveys and data collection are a good first step, but there is a long way to go to understand the unique health needs of all members of the LGBT community. Understanding the demographics of the persons who make up this community is a key first step to understanding how environmental and social determinants may contribute to the health disparities they face. Overwhelming evidence shows that racial and ethnic minorities experience greater health disparities than the general population. In 2010, ACP published an updated position paper on racial and ethnic disparities in health care, which identified various statistics on health disparities in racial and ethnic minority groups, such as higher levels of uninsured Hispanics than white persons (34% vs. 13%) and lower rates of medication adherence in minority Medicare beneficiaries diagnosed with dementia (52). Persons who are part of both the LGBT community and a racial or ethnic minority group may face the highest levels of disparities. For example, data show that 30% of African American adults who identify as lesbian, gay, or bisexual are likely to delay getting a prescription compared with 19% of African American heterosexual adults (26).

Transgender persons may also face certain increased risk factors that can affect their health that are not included when discussing the LGBT population as a whole, which creates research gaps with the LGBT community. A survey study of transgender persons shows elevated reports of harassment, physical assault, and sexual violence (20). In addition, transgender persons are more likely to face discrimination in education, employment, housing, and public accommodations than other sexual, racial, or ethnic minority groups. The lack of and unfamiliarity with research focused on the physical health issues of transgender persons, such as hormone replacement therapy and cancer risk, limit the understanding or development of best practices that could reduce the disparities felt by this population. The dearth of such research is detrimental to physicians' understanding of issues unique to transgender patients and reduces their ability to care for these patients.

Data that have been gathered in the relatively short time since the inclusion of sexual orientation, gender identity, and same-sex marital status have revealed information that can be used to create tailored plans to decrease health disparities in in the LGBT community. For example, in 2009 the California Health Interview Survey collected information on certain health indicators and included sexual orientation along with racial and minority status. The survey found a higher rate of uninsured lesbian, gay, or bisexual Latino adults in the state than their African American counterparts (36% vs. 14%) (20).

In addition to obtaining information from population surveys, including gender identity and sexual orientation as a component of a patient's medical record (paper or electronic) may help a physician to better understand an LGBT patient's needs and provide more comprehensive care. This can be particularly useful in the care of transgender persons, whose gender identity and gender expression may differ from their sex assigned at birth and are not in line with the standard sex template on many forms. Including this information—especially in electronic health records that can standardize information, such as anatomy present and the preferred name/pronoun—can create a more comfortable experience for the patient and keep the physician up to date on the patient's transition history, if applicable (53). If a physician uses paper medical records, the patient's chart should be flagged using an indicator, such as a sticker, to alert staff to use the preferred name and pronoun of the patient (54).

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

Establishing understanding, trust, and communication between a physician and a patient is key to an

ongoing and beneficial physician–patient relationship. However, reported instances of physician bias or denial of care to LGBT patients may influence patients to withhold information on their sexual orientation, gender identity, or medical conditions that could help the physician have a better understanding of the potential health needs of their patients. Physicians can play an integral role in helping an LGBT patient navigate through the medical system by providing respectful, culturally, and clinically competent care that underscores the overall health of the patient. In an article published in *The New England Journal of Medicine,* Makadon noted how physicians can create a welcoming and inclusive environment to LGBT patients:

> [G]uidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be experts on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary. (55)

Providing clinically and culturally competent care for transgender persons in the primary care setting may present a challenge to physicians who are not knowledgeable about transgender health. Transgender persons have reported encounters with physicians who are unaware of how to approach treatment of a transgender person, and half of transgender patients reported having to "teach" their physician about transgender health (20). The National Transgender Survey found that 19% of participants had been denied medical care because of their transgender status (20). Resources for physicians on how to approach the treatment of transgender patients should emphasize respecting the patient's gender identity while providing prevention, treatment, and screening to the anatomy that is present (56).

To better understand the unique health needs of the LGBT community, physicians and medical professionals must develop a knowledge base in cultural and clinical competency and understand the factors that affect LGBT health; this should begin in the medical school setting and continue during practice. Assessment of LGBT-related content at medical schools found a median of 5 hours spent on LGBT-related issues over the course of the curriculum (57). Exposure to members of the LGBT population in medical school has been shown to increase the likelihood that a physician will take a more comprehensive patient history, have a better understanding of LGBT health issues, and have a more positive attitude toward LGBT patients (58). Studies show that undergraduate students pursuing a career in medicine are receptive to incorporating LGBT-related issues into their education and agree that it applies to their future work (59). The College recognizes the importance of incorporating LGBT health into the medical school curriculum and publishes a comprehensive medical textbook on LGBT health, *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition* (60).

In November 2014, the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development released a comprehensive report recommending strategies on how to implement changes in academic medical institutions to better address the needs of LGBT patients; further, the committee identified challenges and barriers to carrying out these changes. The report recognizes 3 methods of integrating LGBT health into the medical school curricula: full curriculum revision, the addition of a required class, or LGBT health study as a part of elective materials. The report also identifies barriers to curricular changes, including but not limited to a lack of material that has been shown to be effective, reluctance of faculty and staff to teach the new material, and a shortage of institutional time that would permit teachers to participate in continuing education on the topic (61).

For some LGBT persons interested in pursuing careers in medicine, there continues to be an underlying concern that their sexual orientation or gender identity may affect their selection into a medical school or residency program and acceptance by their peers. In 2012, Dr. Mark Schuster published his personal story about being gay in medicine starting in the 1980s when he entered medical school, through residency, and into practice. In his article, he spoke of a former attending physician he worked under who acted as an advisor and had indicated he would offer him a recommendation for residency, only to find this physician later renege on that offer after Dr. Schuster shared that he was gay (62). Little research has been done on the recruitment of LGBT physicians into the practice of medicine or how disclosing sexual orientation may affect training. One survey measuring the perceptions and attitudes toward sexual orientation during training found that 30% of respondents did not reveal their sexual orientation when applying for residency positions for fear of rejection (63).

Academic medical institutions can make efforts to create a welcoming and inclusive environment for students and faculty. The University of California, San Francisco, LGBT Resource Center developed a checklist for medical schools to assess LGBT curriculum, admissions, and the working environment within their institution. The checklist includes inclusive application procedures,

measurement of retention of LGBT students, and efforts and resources dedicated to student well-being (64). In a 2013 white paper, the Gay and Lesbian Medical Association made several recommendations to support an LGBT-inclusive climate at health professional schools in such areas as institutional equality, transgender services and support, diversity initiatives, admissions, staff and faculty recruitment and retention, staff and faculty training, and other areas that underscore simple yet thoughtful ways to create an accepting environment for LGBT students, faculty, and employees (65). Tools such as these can assist in recruiting and retaining LGBT physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

Since 1973, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has not considered homosexuality an illness (66). All major medical and mental health organizations do not consider homosexuality as an illness but as a variation of human sexuality, and they denounce the practice of reparative therapy for treatment of LGBT persons (67). The core basis for "conversion," "reorientation," or "reparative" therapy, which is generally defined as therapy aiming at changing the sexual orientation of lesbian women and gay men, is mostly based on religious or moral objections to homosexuality or the belief that a homosexual person can be "cured" of their presumed illness.

In 2007, the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change sexual orientation. It found serious flaws in the research methods of most of the studies and identified only 1 study that met research standards for establishing safety or efficacy of conversion therapy and also compared persons who received a treatment with those who did not. In that study, intervention had no effect on the rates of same-sex behavior, so it is widely believed that there is no scientific evidence to support the use of reparative therapy (68). The Pan American Health Organization, the regional office for the Americas of the larger World Health Organization, also supports the position that there is no medical basis for reparative therapy and that the practice may pose a threat to the overall health and well-being of an individual (69). Dr. Robert Spitzer, the author of a 2003 research study often cited by supporters of the reparative therapy movement to purport that persons may choose to change their sexual orientation, has denounced the research as flawed and apologized to the LGBT community in a letter for misinterpretations or misrepresentations that arose from the study (70).

Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses (71). The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality (68).

States have delved into the debate over the use of reparative therapy for minor children given the potential for harm. California; New Jersey; and Washington, DC, have enacted laws banning the practice. Several other state legislatures, such as those in Washington state, Massachusetts, New York, and Oregon, have introduced or passed legislation through one chamber but failed to pass the bill into law (72). The New Jersey law was challenged on the grounds that the ban limited the free speech of mental health professionals, but the law was upheld by the Third U.S. Circuit Court of Appeals (73). In May 2015, the U.S. Supreme Court declined to hear a challenge to the law (74).

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Persons who are considered at increased or possible risk for certain infectious diseases, such as intravenous drug users, recipients of animal organs or tissues, and those who have traveled or lived abroad in certain countries, are prohibited by the U.S Food and Drug Administration from donating blood (75). Since the early 1980s, the policy has also included men who have sex with men (MSM) since 1977. This lifetime deferral of blood donation for MSM was instituted during a time when the incidence of HIV and AIDS increased to epidemic levels in the United States, and the disease and how it was transmitted were largely misunderstood by the scientific community. In the following years, concerted efforts by the medical community, patient advocates, and government officials and agencies resulted in advancements in blood screening technology and treatments for the virus. However, during that time of uncertainty, policies were implemented to balance the risk for contaminating the blood supply with what was known about the transmissibility of the disease.

Several medical organizations support deferral policy reform based on available scientific evidence and

testing capabilities. The American Medical Association policy on blood donor criteria supports, "the use of rational, scientifically based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk" (76). The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have long advocated for a modification to deferral criteria to be "made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections" and recommend a 12-month deferral for men who have had sex with another man since 1977, which is in line with deferral criteria for others who have exhibited high-risk behavior (77). The eligibility standards and policies on the donation of tissues or tissue products (5-year deferral since last sexual contact) (78) and vascular organs (risk assessed individually, disclosed to transplant team, and consent required) (79) by MSM also reflect a measured assessment of disease transmission risk to donor recipients.

Many countries, including the United Kingdom, Canada, Finland, Australia, and New Zealand, have successfully instituted deferral periods ranging from 12 months to 5 years in lieu of a lifetime ban on blood donation by MSM without measurable increased risk to the blood supply. A study of the risk of blood donations from MSM after the implementation of shorter deferral periods in England and Wales 12 months after their last sexual encounter found only a marginal increase in the risk for transfusion-transmitted HIV (80). Australia changed the deferral policy for MSM from 5 years to 12 months over 1996 to 2000. A study that compared the prevalence of HIV among blood donors from the 5-year deferral period compared with the 12-month deferral period found no evidence that the 12-month period increased risk for HIV in recipients (81).

In late 2014, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted in favor of recommending a 1-year deferral policy for MSM and increased surveillance of the blood supply. The U.S Food and Drug Administration announced it would be updating its policy on blood donation from MSM after considering recommendations made by the HHS, reviews of available scientific evidence, and recommendations from its own Blood Products Advisory Committee. The policy about indefinite deferral on blood donation from MSM is being updated to a 1-year deferral period from the last sexual contact, and the U.S. Food and Drug Administration will issue draft guidance on the policy change in 2015. In addition, the agency announced it has already taken steps to implement a national blood surveillance system to monitor what, if any, effects the new policy has on the nation's blood supply (82). Lifting the lifetime ban on blood donation by MSM is an important first step toward creating equity among those wishing to donate blood. The U.S Food and Drug Administration should continue to monitor the effects of a 1-year deferral and update its policy as information and data are gathered through surveillance to make further strides toward policies that assess donor eligibility on the basis of scientific data and individual risk factors, such as the length of time since a high-risk behavior has occurred, type of sex that occurred, number of partners during a period of time, or a combination of factors (83).

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AAMFT Social Policies

2017 Policy on Social and Family Policies

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Family policy issues are defined as those issues fundamentally concerned about families as the basic institution of our society. Society depends upon families to perform certain essential tasks throughout the life cycle that no other institution of our society is able to carry out as well. As defined in the growing literature that is shaping and defining the domain of family policy issues, family policy generally includes four basic areas of family functioning that directly and explicitly concern:

- Family Composition: Those issues and policies that affect families.
- Economic Support: Those issues and policies that affect families' responsibility and ability to provide for their dependents' basic needs.
- Child-Rearing: Those issues and policies that concern families' responsibility and ability to nurture and rear their children.
- Family Care: Those issues and policies that concern families' responsibility and ability to care for, and related to, relatives of all ages.

Family policies are those issues and policies that either reinforce or interfere with the four basic major categories of family functioning identified above.

Goals for actions concerning family relevant issues by the Board of Directors and the Association are to:

- Educate Members
- Contribute to the public discourse
- Protect and enhance the ability of the profession to serve families
- Influence public policy

The Board of Directors and Association shall be guided in selection of relevant social and family issues by consideration of whether issues are those that are:

- Commanding issues that make a significant difference for the practice of marriage and family therapy and/or
- Commanding issues that make a significant difference for the well-being of families and relationships

Process for Identification, Selection, and Study of Family Policy Issues

- Issues are identified through a variety of initiating sources. These sources include members of the AAMFT Board of Directors, the membership of the AAMFT staff, and the general AAMFT membership.
- When potential issues are identified, the President of the AAMFT Board of Directors shall appoint a Task Force to conduct an initial review of each of the issues that are identified. This Task Force shall recommend to the Board which issues merit further study and consideration by the AAMFT.
- For each issue recommended for further study, the Task Force may recommend the process for review and study and, in consultation with the CEO, the fiscal and human resources necessary to complete such a review and study.
- If a decision is made by the Board that further study is required, the President, in consultation with and as approved by the Board, will establish a mechanism to study the issue (e.g., appointment of Task Force, direction to CEO, or other mechanism appropriate to the issue identified). Study of identified issue should include
    - A primary emphasis on familial/relational aspects;
    - Role of the larger context (e.g., community, political/ideological, socio-cultural, legal, and/or historical);
    - Consideration of the effect of policy options on the practice and profession of marriage and family therapy, client families of marriage and family therapists, and the context directly pertinent to the well-being of families; and
    - Explicit consideration of ethics and values.
- The study process may include, but is not limited to, the following: a review of the relevant literature and other available information, input from and dialogue with AAMFT members, information presented and discussions held in conjunction with the AAMFT Annual Conference and other public conversations and communications.
- The completed study shall be presented to the Board and may include recommendations for the Board's consideration.
- Recommendations to the Board in any report provided by Task Forces or staff, or via other reporting mechanisms, may include, but are not limited to:
    - No further action by the Board of Directors;
    - Further study;
    - Dissemination of information to the membership, public, and/or media;
    - Possible mechanisms for continued dialogue;

- Possible collaboration with other organizations or entities;
- Adoption of a formal position and a rationale for that position; and
- Adoption of a formal position and a rationale for that position, with associated advocacy activities.

- Recommendations may be accompanied by analysis of the fiscal and human resources necessary to implement the recommendations as appropriate.

Positions on Couples and Families

Amicus Briefs filed in Same-Sex Marriage Cases

Over the last two years, AAMFT has joined with the American Psychological Association and other mental health associations in filing briefs in federal courts that support the right of same-sex couples to marry under state law. For example, on March 6, 2015, AAMFT, along with the Michigan Association for Marriage and Family Therapy, joined in a brief filed with the U.S. Supreme Court that is in support of parties who are challenging laws in four states that deny the status of marriage to same-sex couples. The Supreme Court is expected to issue its decision in this matter in June 2015.

The purpose of these briefs, known as amicus briefs, is alert a court to issues relevant to the lawsuit that the parties to the lawsuit might not adequately address. Many professional membership associations file such briefs concerning issues of importance to their members.

Reparative/Conversion Therapy

Adopted by the Board of Directors at its March 25, 2009 Meeting in Alexandria, VA

From time to time AAMFT receives questions about a practice known as reparative or conversion therapy, which is aimed at changing a person's sexual orientation. As stated in previous AAMFT policy, the association does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for such therapy. AAMFT expects its members to practice based on the best research and clinical evidence available. For a review of research on these therapies, please click here.

AAMFT Position on Couples and Families

Adopted by the Board of Directors at its October 17, 2005 meeting in Kansas City, MO

AAMFT believes that all couples who willingly commit themselves to each other, and their children, have a right to expect equal support and benefits in civil society. Thus, we affirm the right of all committed couples and their families to legally equal benefits, protection, and responsibility.

As opportunities arise, AAMFT will support public policy initiatives that strengthen marriages, couples, civil unions, and families through the provision of technical assistance.

What is Marriage and Family Therapy?

Approved by the Board of Directors at its July 31, 2005 meeting in Santa Rosa, CA

Marriage and Family Therapy has long been defined as an intervention aimed at ameliorating not only relationship problems but also mental and emotional disorders within the context of family and larger social systems.

Today, as many in the United States are debating issues of marriage and family composition, it is of primary importance that the American Association for Marriage and Family Therapy and marriage and family therapists make clear what we mean and wish to imply in the use of the words “marriage” and “family” as we use them in our core values, teaching, treatment, research, and code of ethics.

We assert the value and positive impact of stable, long-term, emotionally enriching relationships. We believe that society is better off when social groupings are created that allow for and support these qualities. We recognize that all family forms have inherent strengths and challenges. As marriage and family therapists we focus our study and skills on how individuals in our society couple – choosing partners and establishing households – and form family groups.

We study and intervene to assist in these relationships whether that means a marriage has occurred in the legal sense, whether there is co-habitation, or other forms of family. We invite members of heterosexual, same-sex, culturally similar, intercultural/interracial and other forms of family composition to engage with marriage and family therapists for relational development and problem solving within their cultural contexts. We welcome all who would seek out our services in order to build strength and health in their lives, relationships, and in society. Our code of ethics states that “Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.” We are an open and inclusive profession and organization.

Statement on Nonpathologizing Sexual Orientation

Adopted by the Board of Directors at its September 7, 2004 meeting in Atlanta, GA

The American Association for Marriage and Family Therapy takes the position that same sex orientation is not a mental disorder. Therefore, we do not believe that sexual orientation in and of itself requires treatment or intervention.

Rationale: The development of the field of marriage and family therapy has included a tradition and perspective that eschewed the medical model. Historically, pathology or the diagnosis of an

individual was not part of our field's heritage or practice. In light of this historical context, AAMFT never considered the possibility of making a statement that defined "pathology," or in the case of sexual orientation "non-pathology." At the same time, we have had a history of stating that discrimination based on sexual orientation (and other personal characteristics such as gender, physical ability, religion, creed, ethnicity, for example) is unethical. At this time, in our society, the debate over the health or legitimacy of same sex orientation is once again a topic of political debate. Therefore, it is time for us to clarify our own record and speak to the issue. We support that same sex orientation is a normal variant of human sexuality that takes a variety of forms and expression.

Future Considerations: We do recognize that treatment of those clients who present feeling confused about or wanting to change their sexual orientation should be undertaken with great care, knowledge, and openness. Therefore, it is our intent as an association to provide information to our members, through clinical care guidelines or other methods, regarding these issues.

Amicus Brief

California Same-Sex Marriage Case. On November 4, 2008, California voters approved Proposition 8. This measure amended the California Constitution to state that only a marriage between a man and woman will be recognized in California. Proposition 8 prohibits the State of California from recognizing same-sex marriages performed after November 4, 2008.

AAMFT Board

Meet AAMFT's Board of Directors.

Understanding the Benefits of Marriage and Family Therapy

Find a Therapist

If you or someone you know is experiencing distress, therapy with a marriage and family therapist (MFT) can help.

Find an MFT

TENEO

Continuing education designed specifically for MFTs. Explore the 85 online courses offered and expand your knowledge on a variety of topics. Start your personalized online classroom and earn CE credits at your own pace.

Earn CEs

BUILD Your Career

Job Connection
Find Licensing Boards
Minority Fellowship Program
COAMFTE Program Accreditation
MFT Education Programs

ENHANCE Knowledge

Online Education & Training
Webinars
Annual Conference
Approved Supervisor Resources
Leadership Symposium

ADVANCE the Profession

Family TEAM
News & Events
Federal
States
Private Payer
Healthcare Reform Database
Practice Protection Fund

Membership

Join AAMFT

Renew membership

Approved Supervisors

My Account

Benefits

American Association for Marriage and Family Therapy
112 South Alfred Street Alexandria, VA 22314-3061
Phone: (703) 838-9808 | Fax: (703) 838-9805

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IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF JULIE H. HAMILTON, PH.D., LMFT'S OBJECTIONS AND RESPONSES TO THE PRELIMINARY INJUNCTION INTERROGATORIES OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 33, and Local Rule 26.1, Plaintiff Julie H. Hamilton, Ph.D., LMFT ("Hamilton"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Interrogatories. Hamilton hereby reserves all objections to the relevance, use or admissibility of any of these Interrogatories and responses. Subject to the foregoing, Hamilton objects and otherwise responds as follows:

1. Please state the name and address of the person or persons answering these interrogatories and if applicable the official position or relationship with the party to whom the interrogatories are directed.

RESPONSE: The person providing the substantive information disclosed in these interrogatory responses, and verifying them under oath, is Plaintiff Julie H. Hamilton, who may be contacted through her undersigned counsel. The objections to these interrogatories are made by the undersigned counsel.

2. Explain the legal basis for your assertion that a minor can legally undergo gender reassignment surgery and breast augmentation without the consent of a parent or legal guardian.

OBJECTION: Hamilton objects to this Interrogatory because it misstates Hamilton's positions. Hamilton further objects to this interrogatory because it expressly calls for a legal conclusion. Hamilton is not a lawyer. The "legal basis" for her positions is provided by her counsel in briefs, and is not a proper subject of interrogatories to Hamilton.

3. Describe in detail everything you included when you sought the informed consent of a minor to conduct any therapeutic practice that seeks to change the minor's sexual orientation or gender identity.

OBJECTIONS: Hamilton objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Hamilton's speech or conduct after the enactment of the Ordinance in suit, Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance. Hamilton will therefore respond to the Interrogatory as if limited to her speech or conduct prior to the enactment of the Ordinance.

Hamilton further objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail everything" she says or does on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to what Hamilton generally says or does, or wishes to say or do, on the requested topic. To the extent Hamilton provides examples, they are not exhaustive or inclusive of "everything" Hamilton says or does, or wishes to say or do, in every context. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Hamilton does not "conduct any therapeutic practice" as if it is something "done" to a client. Hamilton's practice involves only talk therapy, which is a conversation that takes place between herself and the client. Hamilton asks the client what his or her goal is and how the client believes Hamilton can be helpful to them during the course of therapy.

When a client presents with a therapeutic goal of conforming their attractions and behaviors to their sincerely held religious beliefs or desires to reduce or eliminate unwanted same-sex attractions, behaviors, identity, or gender confusion, Hamilton discusses the reasons why the client desires such counseling. Hamilton explains that there are no absolute guarantees in mental health counseling. Hamilton explains that behavior and thoughts are changeable, but that there is no guarantee feelings or attractions will always change. Hamilton also informs the client that while many clients can and do experience a successful reduction or elimination of their unwanted same-sex attractions, behaviors, or identity or gender confusion, there is no guarantee that such results are always attainable or equal in degree.

4. Describe in detail everything you included when you sought the informed consent of a minor to conduct any therapeutic practice that seeks to reduce or eliminate "unwanted same-sex attractions or behaviors."

OBJECTIONS: Hamilton objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Hamilton's speech or conduct after the enactment of the Ordinance in suit, Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance. Hamilton will therefore respond to the Interrogatory as if limited to her speech or conduct prior to the enactment of the Ordinance.

Hamilton further objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail everything" she says or does on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to what Hamilton generally says or does, or wishes to say or do, on the requested topic. To the extent Hamilton provides examples, they are not exhaustive or inclusive of "everything" Hamilton says or does, or wishes to say or do, in every context. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Hamilton does not "conduct any therapeutic practice" as if it is something "done" to a client. Hamilton's practice involves only talk therapy, which is a conversation that takes place between herself and the client. Hamilton asks the client what his or her goal is and how the client believes Hamilton can be helpful to them during the course of therapy.

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5. Describe in detail everything you wish to be able to say outside of a therapy session that you contend is prohibited by the County's ordinance.

OBJECTIONS: Hamilton objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail everything" she wishes to say or do on the requested subject. This is impossible to do in an interrogatory response, particularly where the Interrogatory purports to ask about every situation "outside of a therapy session" that Hamilton would ever find herself in, or every speech, communication, presentation or interaction "outside of a therapy session" that Hamilton would ever participate in. Hamilton will therefore respond to the Interrogatory as if limited to what Hamilton generally might wish to say in some instances outside of a formal therapy session. To the extent Hamilton provides examples, they are not exhaustive or inclusive of "everything" Hamilton wishes to say in every context. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

Hamilton further objects to this Interrogatory because it calls for a legal conclusion. Hamilton is not a lawyer, but will provide her understanding of how the Ordinance, which is vague and ambiguous, appears to work in some instances.

RESPONSE: Hamilton notes that, according to the Ordinance, so-called "conversion therapy" – which Hamilton has never used to describe her practice and knows of no other licensed mental health professional who employs such term – means "the practice of seeking to change an individual's sexual orientation or gender identity, including but not limited to efforts to change behaviors, gender identity, or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender or sex." Hamilton notes that the Ordinance also states that, "It shall be unlawful for any Provider to engage in conversion therapy on any minor regardless of whether the Provider receives monetary compensation in exchange for such services."

Hamilton is left to guess at any number of situations in which these provisions would prohibit her from discussing certain issues outside of a formal therapy session. Based on the Ordinance, as a licensed provider, Hamilton is not permitted to attempt to help a minor with changes the minor wishes to make, even if she is not getting paid. Even if Hamilton

is outside of her counseling office, and merely talking to or trying to help a friend's son or daughter address their unwanted same-sex attractions, behaviors, identity, or gender confusion, the Ordinance would prohibit that kind of speech. Under the Ordinance, Hamilton also notes that such a restriction would apply to conversations she would have with her own children or with other children in her extended family.

The Ordinance prohibits "the practice of seeking to change," which in Hamilton's field consists of conversations between her and those whom she is trying to help. Therefore, the Ordinance prohibits Hamilton from even having conversations that would seek to help minors with changes they wish to make in the areas prohibited by the Ordinance, even if she is outside the office, not getting paid for such help. Hamilton also notes that such a broad prohibition may even apply to her giving lectures, speeches, or lessons at a church or local organization that desires to assist parents and children who are struggling with such issues.

Hamilton would also like to be able to advertise her services to minors who seek to reduce or eliminate their unwanted same-sex attractions, behaviors, identity, or gender confusion (and their parents). Hamilton would like to be able to advertise on websites, through radio, in published print, in brochures, through verbal communications, and via other mechanisms to offer her services in this area. Because of the Ordinance, however, Hamilton is prohibited from distributing such advertisements because she cannot advertise something that she is not legally permitted to offer.

6. Describe in detail everything you wish to be able to say in therapy to a minor patient that you contend is prohibited by the County's ordinance.

OBJECTIONS: Hamilton objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail everything" she wishes to say or do on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to what Hamilton generally might wish to say in some instances in a therapy session with a minor. To the extent Hamilton provides examples, they are not exhaustive or inclusive of "everything" Hamilton wishes to say in every context. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

Hamilton further objects to this Interrogatory because it calls for a legal conclusion. Hamilton is not a lawyer, but will provide her understanding of how the Ordinance, which is vague and ambiguous, appears to work in some instances.

RESPONSE: Hamilton contends that the Ordinance is prohibiting her from saying anything that might possibly be construed, understood, or inferred to be seeking to help a minor reduce or eliminate unwanted same-sex attractions, behaviors, or identity or gender confusion, even when such statements are not uttered with the express aim of changing a

minor's sexual orientation or gender identity. Hamilton notes that she does not engage in therapy where her goal is to change any client's sexual orientation or gender identity, but that she seeks to help clients achieve the goals that the clients themselves determine are appropriate for them. Under the Ordinance, not only is Hamilton prohibited from engaging in such talk therapy with her clients, but her clients are prohibited from even having certain goals in the therapeutic alliance, even when those goals are necessary for the clients to live consistently with their sincerely held religious beliefs, values, and concept of self.

Hamilton cannot possibly describe in this response every potential issue or statement that she might like to address in a therapeutic setting because her talk therapy practice is never the same for every client. Hamilton's practice focuses on conversations and discussions that address what the clients present with, what the clients wish to explore or address, and the goals and aims that the clients wish to pursue.

As it relates to potential clients who present with unwanted same-sex attractions, behaviors, or identity, Hamilton in some instances would like to ask questions such as: "Since you are distressed about being in a relationship with a boy [or girl, for female clients], would you like to talk about ways you can get out of that relationship? What ideas have you thought of so far? What have you tried? What steps would you like to take? What purpose is that relationship filling in your life?" Hamilton might also discuss things related to identifying and addressing underlying issues, such as sexual abuse, pornography exposure, or familial relationship issues. The Ordinance prohibits these kinds of discussions because they may lead to change or may be construed as "efforts to change."

If a client appears to be adopting a sexual identity label for external reasons (such as to fit in, to anger the parents, or due to confusion inflicted by cultural messages) rather than having a true internal sense of that identity, Hamilton is not permitted to explore any changes to that "identity" – even if that "identity" does not conform with the individual's true concept of self.

As it relates to potential biological male clients who present with gender confusion or gender identity issues, Hamilton in some instances would like to ask questions such as: "What do you like/not like about boys? What do you like/not like about girls? At what times or in what circumstances do you feel more confident as a boy? When do you enjoy being a boy?" The Ordinance prohibits these kinds of discussions because they may lead to change or may be construed as "efforts to change."

7. Describe in detail what "talk therapy" practices you employed, prior to the passage of the County's ordinance, to reduce or eliminate same-sex attractions. Specify what concepts and information you communicated as "truth," what advice was generally given, and what tools you generally recommended the minor employ.

OBJECTIONS: Hamilton objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail" the therapy she provided and advice she gave to every SOCE counseling client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to Hamilton's general approach to talk therapy with same-sex attracted clients prior to the enactment of the Ordinance. To the extent Hamilton provides examples, they are not exhaustive or inclusive of everything Hamilton said or did in such therapy sessions. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Hamilton notes that she does not try to eliminate attractions, just as she does not claim she can eliminate any distressing issue that any client presents in therapy. With regard to reducing same-sex attractions, behaviors, or identity, this is sometimes the result of the client better understanding the attractions and addressing underlying issues. Hamilton's practice deals only with assisting clients achieve their own goals, addressing the issues the clients wish to address, and focusing solely on the clients' needs.

With regard to Hamilton's approach, she is a client-centered family therapist. She seeks to work from the client's frame of reference, honoring the client's perspective and using the resources that the client presents. Hamilton explores the client's perspective and does not enter any therapeutic alliance with any preconceived notions of what goals or issues the client may wish to address. Hamilton also searches for client strengths and builds on those strengths. In addition, Hamilton works to understand and strengthen family relationships. She helps clients to understand the root causes of their feelings or behaviors, and also helps them to make the changes they are seeking.

Many of Hamilton's clients identify themselves as Christians and have sincerely held religious beliefs that the Bible is the only source of truth. Various Biblical truths are sometimes discussed with these Christian clients.

The tools that Hamilton typically deploys are primarily ideas that she can elicit from the client. She believes in client-centered therapy, and that the most effective ideas are those that the client brings up. In addition, Hamilton asks questions, listens, empathizes, seeks to expand options for the client, introduces possible explanations, such as sharing theories of attachment and the role of early parental nurture, and explores whether or not such theories fit for the client.

Hamilton incorporates her response to Interrogatory 6 for additional illustrations of her talk therapy sessions with same-sex attracted clients prior to the enactment of the Ordinance.

8. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the efficacy of the therapy you describe in your answer to interrogatory number 7 above.

OBJECTION/RESPONSE: Hamilton objects to this Interrogatory on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible article, research paper, report, etc. that supports the use of client-centered therapy. Construing this Interrogatory as limited to those articles, research papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time of this response, Hamilton provides the following response: See PLJoint 081-793 produced in response to the County's Requests for Production. In addition, see:

de Shazer, S. (1985). *Keys to solution in brief therapy*. New York: W. W. Norton.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with impossible cases: Efficient treatment of therapy veterans*. New York: W. W. Norton.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997, July/August). Stepping off the throne. *Family Therapy Networker*, 22-33.

Duncan, B. L., Hubble, M. A., Rusk, G. (1994). To intervene or not to intervene? That is not the question. *Journal of Systemic therapies, 13*, (4), 22-30.

Duncan, B. L., & Miller, S. D. (2000) *The heroic client: Doing client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass.

Hubble, M. A., Miller, S. D., & Duncan, B. L. (Eds.). (1999). *The heart and soul of change: What works in therapy*. American Psychological Association.

Miller, S. D., Hubble, M. A., & Duncan, B. L. (Eds.) (1996) *Handbook of solution-focused brief therapy*. San Francisco: Jossey-Bass.

Selekman, M. D. (1997). *Solution-Focused Therapy with children: Harnessing the strengths for systemic change*. New York: Guilford Press.

Walter, J. L., & Peller, J. E. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner/Mazel.

9. Describe in detail what "talk therapy" practices you employed, prior to the passage of the County's ordinance, to seek to change a minor's sexual orientation or gender identity. Specify what concepts and information you communicated as "truth," what advice was generally given, and what tools you generally recommended the minor employ.

OBJECTIONS: Hamilton objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail" the therapy she provided and advice she gave to every SOCE counseling client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to Hamilton's general approach to talk therapy with same-sex attracted clients or gender confused clients prior to the enactment of the Ordinance. To the extent Hamilton provides examples, they are not exhaustive or inclusive of everything Hamilton said or did in such therapy sessions. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Hamilton notes that she does not try to change her clients' sexual orientation or gender identity. Hamilton's practice deals only with assisting clients achieve their own goals, addressing the issues the clients wish to address, and focusing solely on the clients' needs.

With regard to Hamilton's approach, she is a client-centered family therapist. She seeks to work from the client's frame of reference, honoring the client's perspective and using the resources that the client presents. Hamilton explores the client's perspective and does not enter any therapeutic alliance with any preconceived notions of what goals or issues the client may wish to address. Hamilton also searches for client strengths and builds on those strengths. In addition, Hamilton works to understand and strengthen family relationships. She helps clients to understand the root causes of their feelings or behaviors, and also helps them to make the changes they are seeking.

Many of Hamilton's clients identify themselves as Christians and have sincerely held religious beliefs that the Bible is the only source of truth. Various Biblical truths are sometimes discussed with these Christian clients.

The tools that Hamilton typically deploys are primarily ideas that she can elicit from the client. She believes in client-centered therapy, and that the most effective ideas are those that the client brings up. In addition, Hamilton asks questions, listens, empathizes, seeks to expand options for the client, introduces possible explanations, such as sharing theories of attachment and the role of early parental nurture, and explores whether or not such theories fit for the client.

Hamilton incorporates her response to Interrogatory 6 for additional illustrations of her talk therapy sessions with same-sex attracted clients prior to the enactment of the Ordinance.

10. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the efficacy of the therapy you describe in your answer to interrogatory number 9 above.

OBJECTION/RESPONSE: Hamilton incorporates by reference, as if fully restated herein, her Objection/Response to Interrogatory 8.

11. Describe in detail what you tell minors in therapy, as part of your therapeutic practice, are the root causes of their "unwanted same-sex attractions, behaviors, and identity."

OBJECTIONS: Hamilton objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Hamilton's speech or conduct after the enactment of the Ordinance in suit, Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance. Hamilton will therefore respond to the Interrogatory as if limited to her speech or conduct prior to the enactment of the Ordinance.

Hamilton further objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail" what she has told every SOCE counseling minor client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to Hamilton's general approach to talk therapy with same-sex attracted clients and gender confused clients prior to the enactment of the Ordinance. To the extent Hamilton provides examples, they are not exhaustive or inclusive of everything Hamilton said or did in such therapy sessions. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: According to the research, there is no conclusive information about the root causes of unwanted same-sex attractions, behaviors, and identity. According to the APA, both nature and nurture play a role. According to the APA Handbook on Sexuality and Psychology (2014), there may be a link between lack of a same-sex parent and later

homosexuality. The authors of various studies have also described a possible correlation between sexual abuse and homosexuality.

In her client-centered therapy, Hamilton does not present theories as facts, but rather as theories. Hamilton asks clients if they would like to hear possible explanations for homosexual attractions and asks if those explanations fit for them or not. In many cases, Hamilton first listens to clients' own experiences and then explains theories that match those experiences. Examples of some contributing factors might include: a sensitive temperament (nature); insecure sense of gender identity in childhood; lack of attachment to the same-sex parent; lack of attachment to same-sex peers; parental rejection; peer rejection; over-identification with the opposite-sex parent in early childhood; over-identification with opposite-sex peers in early childhood; sexual abuse or early sexual exposure, such as through pornography; cultural influences; and so forth. Every person is different. Hamilton believes there are many pathways into and out of homosexuality. Therefore, Hamilton does not impose narrow explanations on individuals but instead explores with each client if and how developmental explanations might fit with their specific experiences.

12. Describe in detail what you tell minors in therapy, as part of your therapeutic practice, about gender roles and identities.

OBJECTION: Hamilton objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Hamilton's speech or conduct after the enactment of the Ordinance in suit, Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance. Hamilton will therefore respond to the Interrogatory as if limited to her speech or conduct prior to the enactment of the Ordinance.

Hamilton further objects to this Interrogatory because it inappropriately calls for a narrative response and requires her to "describe in detail" what she has told every SOCE counseling minor client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy she practices, where no two interactions are exactly alike. Hamilton will therefore respond to the Interrogatory as if limited to Hamilton's general approach to talk therapy with same-sex attracted clients and gender confused clients prior to the enactment of the Ordinance. To the extent Hamilton provides examples, they are not exhaustive or inclusive of everything Hamilton said or did in such therapy sessions. Hamilton is prepared to supplement her response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Hamilton does not currently recall a specific conversation with a minor concerning gender roles prior to the enactment of the Ordinance. However, if a minor asked for information about gender differences or identities, Hamilton would talk about gender from the point of view that all people are either male or female (unless born with an intersex condition) and that there are wonderful differences between males and females. Hamilton would discuss that we each have a purpose and that we find the most peace in embracing who we were born to be.

13. Describe the principles and methods of the "talk therapy" practices you wish to use but claim that you cannot because of the passage of the County's ordinance.

OBJECTION/RESPONSE: Hamilton incorporates by reference, as if fully restated herein, her Objections and Responses to Interrogatories 6, 7 and 9.

In addition, Hamilton states that, because the Ordinance is vague and ambiguous, she does not know how the County is interpreting and applying it, and she does not know the full extent of what the Ordinance prohibits. In essence, the Ordinance prohibits Hamilton from assisting her minor clients in accomplishing the goals they have for their lives, many of which arise because of their sincerely held religious beliefs, values, and concept of self. Some of her clients' goals are no longer permissible under the Ordinance. The County has taken away the fundamental right of certain clients to self-determination in that they cannot have the goals of changing homosexual behaviors, seeking to understand and thereby diminish, if possible, homosexual attractions; and becoming more secure in their biological sex when their gender identity does not match their biological sex.

14. Describe the principles and methods of the "talk therapy" practices that can reduce or eliminate same-sex attractions.

OBJECTION/RESPONSE: Hamilton incorporates by reference, as if fully restated herein, her Objections and Responses to Interrogatories 6, 7 and 9.

In addition, therapy for clients who present with sincerely held religious beliefs, values, goals, or desires to address issues relating to reducing unwanted same-sex attractions is similar to therapy for other issues. There are many mainstream methods that have been found to be useful, such as Interpersonal Therapy, Psychodynamic Therapy, Cognitive Therapy, etc. Hamilton's personal approach is a client-directed, solution-focused approach that also includes Family Therapy, Attachment Theory, and Psycho-education.

15. Describe the principles and methods of the "talk therapy" practices that can change a minor's sexual orientation or gender identity.

OBJECTION/RESPONSE: Hamilton incorporates by reference, as if fully restated herein, her Objections and Responses to Interrogatories 6, 7, 9 and 14.

In addition, Hamilton works with parents to help them relate in more effective ways. For younger children, Hamilton spends more time with the parents and less time with the child. For older children, Hamilton might spend equal time with parent and child. For teenagers, Hamilton might spend more time with the teen and less time with the parent, depending on the specific situation.

16. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the conclusion that unwanted same-sex attractions result from trauma.

OBJECTION/RESPONSE: Hamilton objects to this Interrogatory on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible article, research paper, report, etc. that supports the correlation between unwanted same-sex attractions and sexual abuse or trauma. Construing this Interrogatory as limited to those articles, research papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time of this response, Hamilton provides the following response:

According to research studies, there is a correlation between sexual abuse and later homosexual relationships. However, not all homosexuals were sexually abused. Another traumatic factor identified by researchers is lack of a same-sex parent.

The APA Handbook on Sexuality and Psychology (2014) states:

> "Much has been written about the association between childhood sexual abuse and subsequent homosexuality. Indeed, studies using varying methodologies have reported a correlation between different types of child abuse and varying components of a homosexual sexual orientation, including data from clinical samples and case studies, surveys of MSM, and cross-sectional surveys (reviewed in Purcell, Patterson, & Spikes, 2007; H. W. Wilson & Widom, 2010). Not all studies, however, have found this pattern of results. Furthermore, some evidence suggests that the relationship may be stronger among men than women. The largest reviews of the literature in this area indicated that MSM report rates of childhood sexual abuse that are approximately three times higher than that of the general male population (Purcell, Malow, Dolezal, & Carballo-Dieguez, 2004). One of the most methodologically rigorous studies in this area used a prospective longitudinal case-control design that involved following abused and matched non-abused children

into adulthood 30 years later. It found that men with documented histories of childhood sexual abuse had 6.75 times greater odds than controls of reporting ever having same-sex sexual partners (H. W. Wilson & Widom, 2010). To help control for possible confounding factors, the authors conducted post hoc analyses controlling for number of lifetime sexual partners and sex work, but the association remained. The effect in women was smaller (odds ratio = 2.11) and a statistical trend (p = .09)."

Hamilton also notes the following articles:

Mustanski, B., Kuper, L., and Geene, G. (2014) Chapter 19: Development of sexual orientation and identity. In Tolman, D., & Diamond, L., Co-Editors-in-Chief, APA Handbook of Sexuality and Psychology, Washington D.C.: American Psychological Association, 1: 609.

Frisch, M. and Hviid, A. (2006). Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes. Archives of Sexual Behavior, 35:533-547.

Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same- sex and opposite-sex interest. Journal of Biosocial Science, 37, 481–497. http://dx.doi.org/10.1017/S0021932004006765 p. 487.

Francis, A. M. (2008). Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 45 (4), 371-377. DOI:10.1080/00224490802398357, p. 376.

17. Have you ever counseled a minor to assist them in coping with wanted same-sex attractions? If so, please identify how many minors you have so helped in the last 5 years.

RESPONSE: If a minor has "wanted same-sex attractions," they typically do not need assistance in coping with those attractions. Thus, Hamilton has not encountered clients who identify as homosexual and desire to live according to that identity, and who need assistance coping with their attractions. Hamilton has had clients who did not want to seek change of attractions, behavior, or gender identity even though their parents hoped they would seek such change. In those cases, Hamilton usually asked the minor if there was a different goal that she could help them accomplish. Some minors said, "no" and other minors identified a different goal. The most common goal of those minors was for Hamilton to help them communicate with their parents or to improve family relationships. Hamilton assisted with those goals.

In the last 5 years, Hamilton has met with 7 minors who wanted their same-sex attractions or transgender identity. Out of the 7 that wanted their same-sex attractions or transgender identities, 4 wanted to return beyond the initial visit to work on another goal, such as family relationships. In those cases, Hamilton helped them work towards their goals, as she always

does in her client-centered and client-directed marriage and family therapy practice.

18. In the year prior to the passage of the County's ordinance at issue, what percentage of your practice involved counseling that sought to change a minor's gender identity of [*sic*] sexual orientation and what percentage of your counseling sought to assist a minor in embracing or coping with a non-heterosexual orientation or a gender identity that differed from their anatomical sex?

RESPONSE: As stated in response to Interrogatory No. 17, Hamilton has not had clients who sought assistance in coping with wanted same-sex attractions or wanted gender identity that is different from anatomical sex, because the clients, who were not seeking change, stated that they were already embracing a non-heterosexual identity or transgender identity. As such, Hamilton was not presented with a client who stated that his or her goal was to be able cope with an attraction or identity that differed from their own concept of self.

Prior to the passage of the Ordinance, Hamilton had 13 minors who sought help with changing their unwanted same-sex attractions, behaviors, or gender identity, and 19 minors who did not want to change their same-sex attractions, behaviors, or gender identity. Hamilton was always willing to work with all of the minors that came to her for therapy, including the clients who were not seeking change, as explained in her response to Interrogatory 17.

19. Explain with specificity and in detail (a) the decline in profit your practice has sustained since or as a result of the passage of the County's conversion-therapy ban ordinance at issue; (b) identify the actual dollar amount of the decline in profit; (c) and identify the specific methodology you utilized to compute (a) and (b) above.

OBJECTION: Hamilton objects to this Interrogatory on the grounds that it is premature. The Preliminary Injunction Hearing is concerned exclusively with the irreparable and incalculable harm that the unconstitutional Ordinance is imposing on Hamilton and her clients each and every day it remains in effect, by virtue of its indiscriminate ban on constitutionally protected speech, and its violation of other constitutional liberties. This is the primary harm this lawsuit seeks to redress. Accordingly, it is not proper for "Preliminary Injunction Interrogatories" to request a calculation of money damages. Hamilton does not seek money damages at the Preliminary Injunction Hearing.

In the subsequent merits and damages phase of discovery following the Preliminary Injunction Hearing, Hamilton will attempt to calculate her lost revenues and profits from the clients she has had to turn away following enactment of the Ordinance, and will provide same to Defendants, provided Defendants stipulate that such disclosure does not amount

to any waiver of Hamilton's Fifth Amendment Privilege with respect to any other information. To the extent lost revenues and profits from clients turned away on account of the Ordinance can be calculated, they would constitute only a portion of the harm suffered by Hamilton and her clients, and they could not make Hamilton or her clients whole for the irreparable harm imposed by the Ordinance.

20. Identify by first and last initial and age only all minor clients with whom you completely terminated your professional relationship because of the passage of the County's ordinance at issue and the date of the termination.

OBJECTION: Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance.

Hamilton further objects to this interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks her to divulge too much identifying information regarding her clients.

Hamilton is willing to provide the number of "Doe" clients or potential clients, and their ages, whom she has had to turn away, or for whom she has had to alter the scope of therapy on account of the Ordinance, but only if Defendants stipulate that such disclosure does not amount to any waiver of Hamilton's Fifth Amendment Privilege, or the psychotherapist-patient privilege, with respect to any other information.

21. Identify by first and last initial and age only all minor clients with whom you substantially changed your professional relationship because of the passage of the County's ordinance at issue.

OBJECTION: Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance.

Hamilton further objects to this interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks her to divulge too much identifying information regarding her clients.
Hamilton is willing to provide the number of "Doe" clients or potential clients, and their ages, whom she has had to turn away, or for whom she has had to alter the scope of therapy on account of the Ordinance, but only if Defendants stipulate that such disclosure does not amount to any waiver of Hamilton's Fifth Amendment Privilege, or the psychotherapist-patient privilege, with respect to any other information.

22. Identify by first and last initial and age only all clients whom were minors (under age 18) when they initially engaged your counseling services that are or were experiencing unwanted same-sex attractions and wanted to reduce or eliminate the unwanted desire within the last ten years.

OBJECTION: To the extent the Interrogatory purports to request information about Hamilton's minor clients after the enactment of the Ordinance in suit, Hamilton objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Hamilton has been forced to alter her speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Hamilton notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Hamilton does not wish to provide the County with any information upon which to prosecute her for any unknowing violations of the Ordinance. Hamilton will therefore respond to the Interrogatory as if limited to the nine (9) years prior to the enactment of the Ordinance.

Hamilton further objects to this Interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks her to divulge too much identifying information in relation to these clients. Hamilton construes this Interrogatory to only request the number and respective ages of clients seeking help for unwanted same-sex attractions or gender identity confusion.

RESPONSE: Hamilton does not have clients whose only goal is to reduce or eliminate unwanted desires, as stated in the Interrogatory. Hamilton makes sure that her clients understand that change of attraction might happen as they work on root issues, but there is no guarantee that desires will change. Her clients' goals usually include wanting to change behaviors, wanting to understand their attractions, and wanting to reduce their attractions if possible. Hamilton also notes that, particularly with minors, goals may change throughout the course of therapy due to the nature of adolescence. Some may not have started with the goal of changing, but may have expressed a desire to change at some point during the course of therapy, and others may have started with the goal of changing and then altered the goal throughout the course of therapy.

In the nine (9) years prior to the enactment of the Ordinance, Hamilton had the following minor clients who sought help with unwanted same-sex attractions or gender identity confusion:

Doe 1 (age 6): gender identity confusion
Doe 2 (age 12): unwanted same-sex attractions or behaviors
Doe 3 (age 16): unwanted same-sex attractions or behaviors
Doe 4 (age 15): unwanted same-sex attractions or behaviors
Doe 5 (age 10): gender identity confusion
Doe 6 (age 17): unwanted same-sex attractions or behaviors
Doe 7 (age 13): unwanted same-sex attractions or behaviors
Doe 8 (age 14): unwanted same-sex attractions or behaviors
Doe 9 (age 17): unwanted same-sex attractions or behaviors
Doe 10 (age 16): unwanted same-sex attractions or behaviors
Doe 11 (age 16): unwanted same-sex attractions or behaviors

23. Do you admit that therapy you wish to provide is a mental health treatment? If not, please explain why.

RESPONSE: Hamilton admits that the SOCE counseling she wishes to provide to the minor clients who seek and desire it is a form of treatment carried out solely through speech, and agrees with the Eleventh Circuit Court of Appeals that characterizing speech as treatment or procedure in an effort to afford it less First Amendment protection is a dubious constitutional enterprise.

24. Do you admit that therapy you wish to provide is professional conduct? If not, please explain why.

RESPONSE: Hamilton denies that the SOCE counseling she wishes to provide to the minor clients who seek and desire it is professional conduct, and agrees with the Eleventh Circuit Court of Appeals that characterizing speech as conduct in an effort to afford it less First Amendment protection is a dubious constitutional enterprise.

As to Objections:

/s/ Horatio G. Mihet
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VERIFICATION

I, Julie H. Hamilton, Ph.D., LMFT, declare under penalty of perjury under the laws of the United States of America that the foregoing interrogatory responses are true and correct.

/s/ Julie H. Hamilton
Julie H. Hamilton, Ph.D., LMFT

CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF JULIE H. HAMILTON, PH.D., LMFT'S RESPONSES AND OBJECTIONS TO THE PRELIMINARY INJUNCTION REQUESTS TO PRODUCE OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 34, and Local Rule 26.1, Plaintiff Julie H. Hamilton, Ph.D., LMFT ("Hamilton"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Requests to Produce. Hamilton hereby reserves all objections to the relevance, use or admissibility of any of these requests and responses, or the responsive documents being produced. Subject to the foregoing, Hamilton objects and otherwise responds as follows:

1. A copy of your resume or curriculum vitae.

RESPONSE: See Hamilton 001-003.

2. A copy of your professional license.

RESPONSE: See Hamilton 004.

3. A copy of your fee schedule, contract, or hourly charges for the type of services you claim you can no longer practice because of the County's ordinance.

RESPONSE: See Hamilton 005-006.

4. A copy of all publications, presentations, studies, research papers, or reports you have created or authored on the subject of sexual orientation or gender identity.

RESPONSE: See Hamilton 007-030; see also DVD Recording: *Homosexuality 101*… (being produced in hard copy via Federal Express)

5. All Codes of Ethics relating to the regulations mental health professionals and counselors, including Licensed Marriage and Family Therapist.

RESPONSE: See PLJoint 001-080. See also Fla. Stat. Ann. § 491.009; and Fla. Admin. Code § 64B4-5.001.

6. A blank copy of the "informed consent" form or script referenced in paragraph 143 of the Complaint.

RESPONSE: See Hamilton 005-006.

7. A copy of all Codes of Ethics relating to the regulations mental health professionals and counselors, including Licensed Marriage and Family Therapists.

RESPONSE: See PLJoint 001-080. See also Fla. Stat. Ann. § 491.009; and Fla. Admin. Code § 64B4-5.001.

8. A copy of all studies, research papers, or reports that support or substantiate the efficacy of any practice that seeks to change the sexual orientation of a minor.

OBJECTION/RESPONSE: Hamilton objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time of this response, Hamilton provides the following response: See PLJoint 081-793.

9. A copy of all studied, research papers, or reports that support or substantiate the efficacy of any practice that seeks to change the gender identity of a minor.

OBJECTION/RESPONSE: Hamilton objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time

of this response, Hamilton provides the following response: See PLJoint 081-793.

10. A copy of all studies, research papers, or reports that support or substantiate the efficacy of any practice that seeks to reduce or eliminate same-sex attractions or feelings of a minor.

OBJECTION/RESPONSE: Hamilton objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time of this response, Hamilton provides the following response: See PLJoint 081-793.

11. A copy of all studies, research papers, or reports that support or substantiate the benefit of sexual orientation change efforts in minors.

OBJECTION/RESPONSE: Hamilton objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Hamilton has reviewed, gained some personal insight from, and recalls as of the time of this response, Hamilton provides the following response: See PLJoint 081-793.

12. A copy of DVD: *Homosexuality 101: Where Does It Come From, Is Change Possible, and How Should Christians Respond?* Referenced on http://drjuliehamilton.com/resources/

RESPONSE: Hamilton is producing the requested DVD via Federal Express.

13. A copy of *Handbook of Therapy for Unwanted Homosexual Attractions: A Guide to Treatment* referenced on http://drjuliehamilton.com/resources/

RESPONSE: Hamilton does not have a copy of this book in her custody, possession, or control. A copy of the requested document is available for purchase at: https://www.amazon.com/Handbook-Therapy-Unwanted-Homosexual-Attractions/dp/1607916010.

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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF JULIE H. HAMILTON, PH.D., LMFT'S RESPONSES AND OBJECTIONS TO THE PRELIMINARY INJUNCTION REQUESTS FOR ADMISSION OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 36, and Local Rule 26.1, Plaintiff Julie H. Hamilton, Ph.D., LMFT ("Hamilton"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Requests for Admission. Unless specifically admitted, each Request or part thereof is hereby DENIED. Any and all admissions are subject to the qualifications and conditions stated in the response containing that admission, and subject to any stated objections. Hamilton hereby reserves all objections to the relevance, use or admissibility of any of these requests and responses. Subject to the foregoing, Hamilton admits, denies, objects and otherwise responds as follows:

1. Admit that your professional conduct is subject to government regulation.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Notwithstanding, Hamilton admits that her professional conduct is subject to government regulation at the state level by the State of Florida Department of Business and Professional Regulation, which licenses and regulates the practice of mental health professions within legal and constitutional boundaries. Hamilton denies that her professional conduct is subject to regulation by local (county or city) governments.

2. Admit that local governments have the power to regulate ineffective medical and mental health treatments.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Notwithstanding, Hamilton denies that local governments have the power to regulate medical and mental health treatments.

3. Admit that local governments have the power to regulate harmful medical and mental health treatments.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Notwithstanding, Hamilton denies that the local governments have the power to regulate medical and mental health treatments.

4. Admit that Palm Beach County has the police power to regulate the practice of professions.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Notwithstanding, Hamilton denies that Palm Beach County has the power to regulate licensed professionals in the conduct or practice of their profession.

5. Admit that Palm Beach County has the police power to legislate in the interest of protecting the physical and psychological well-being of minors.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Notwithstanding, Hamilton admits that Palm Beach County has the power to legislate in the interest of protecting the well-being of minors, but only to the extent such legislation is authorized under the Florida Constitution and statutes, and only if such legislation does not violate statutory or constitutional protections.

6. Admit that protecting the physical and psychological well-being of minors is a legitimate government interest.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Hamilton admits that protecting the well-being of minors from provable serious or fatal harm is a legitimate government interest. Hamilton otherwise denies this request.

7. Admit that Palm Beach County has a compelling interest in protecting the physical and psychological well-being of minors.

OBJECTION/RESPONSE: Hamilton objects to this request to because it calls for a legal conclusion. Notwithstanding, Hamilton admits that protecting the well-being of minors from provable serious or fatal harm is a compelling government interest. Hamilton otherwise denies this request.

8. Admit that protecting the integrity and ethics of medical and mental health professions is a legitimate government interest.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls of a legal conclusion. Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Hamilton admits that protecting the integrity and ethics of medical and mental health professions, subject to constitutional and statutory protections, is a legitimate government interest for those governmental bodies constitutionally and statutorily empowered to regulate such professions, in this case the State of Florida and its agencies. Hamilton denies that protecting the integrity and ethics of medical and mental health professions is a legitimate interest of local governments.

9. Admit that Palm Beach County has a compelling interest in protecting the integrity and ethics of medical and mental health professions.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls of a legal conclusion. Notwithstanding, Hamilton denies this request.

10. Admit that a government's authority over minor's activities is broader than like actions of adults.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls of a legal conclusion. Hamilton further objects to this request because it is vague and ambiguous in that it fails to specify the "activities" as to which it seeks an admission or the level or branch of "government" to which it refers. Notwithstanding, Hamilton admits that, subject to constitutional and statutory protections, an appropriate government body may regulate certain activities of minors, such as driving, smoking or drinking, to a greater extent than it can for adults. Hamilton denies that any government body can exceed its proper authority, violate or intrude upon the parent-child relationship, override the parents' duty or responsibility to direct the upbringing of their children, or otherwise violate the statutory or constitutional rights of minors or adults.

11. Admit that being lesbian, gay, bisexual, or transgender is not a mental disease.

OBJECTION/RESPONSE: Hamilton objects to this request because it is compound. Hamilton further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental disease." Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Hamilton admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

12. Admit that being lesbian, gay, bisexual, or transgender is not a mental disorder.

OBJECTION/RESPONSE: Hamilton objects to this request because it is compound. Hamilton further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental disorder." Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Hamilton admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

13. Admit that being lesbian, gay, bisexual, or transgender is not a mental illness.

OBJECTION/RESPONSE: Hamilton objects to this request because it is compound. Hamilton further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental illness." Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Hamilton admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

14. Admit that being lesbian, gay, bisexual, or transgender is not a deficiency.

OBJECTION/RESPONSE: Hamilton objects to this request because it is compound. Hamilton further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "deficiency." Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Hamilton admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria." Hamilton also admits that many patients believe that their same-sex attractions

or feelings, or their gender identity confusion, feels like a deficiency to them, for which they would like counseling. Lastly, Hamilton admits that people experiencing same-sex attractions or feelings, or gender identity confusion, are not "deficient" or less valuable than other persons.

15. Admit that being lesbian, gay, bisexual, or transgender is not a shortcoming.

OBJECTION/RESPONSE: Hamilton objects to this request because it is compound. Hamilton further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "shortcoming." Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Hamilton admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria." Hamilton also admits that many patients believe that their same-sex attractions or feelings, or their gender identity confusion, feels like a shortcoming to them, for which they would like counseling. Lastly, Hamilton admits that people experiencing same-sex attractions or feelings, or gender identity confusion, are not less valuable than other persons.

16. Admit that, in therapy, you only affirm or encourage a minor's sexual orientation if it is heterosexual.

RESPONSE: Denied.

17. Admit that, in therapy, you do not affirm or encourage a minor's homosexual orientation.

RESPONSE: Denied. Hamilton states that, in therapy, she does not affirm or deny a minor's homosexual orientation. Instead, Hamilton listens to understand the client's perspective and addresses the underlying issues leading to the client's distress.

18. Admit that, in therapy, you do not affirm or encourage a minor's gender identity if it differs from the minor's anatomical sex.

RESPONSE: Hamilton objects to this request because it is vague and ambiguous. Hamilton is unable to admit or deny the request as stated, as a blanket statement, because Hamilton follows a case-by-case approach which takes into account the age and maturity level of her minor clients, the clients' stated goals and desires, and the clients' individual therapeutic needs. Hamilton's general practice is to listen and try to understand the client's perspective and to address the underlying issues leading to the client's distress.

19. Admit that "aversion therapy" techniques used in conversion therapy, such as inducing nausea, vomiting or paralysis; providing electronic shocks; or snapping a rubber band around a patient's wrist when the patient becomes aroused to same-sex erotic images or thoughts are unethical in your profession.

RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit, since no licensed mental health professional she knows has ever or would ever use such techniques as part of SOCE counseling. Notwithstanding, Hamilton admits that it would be unethical to perform any of the above-listed methods in SOCE counseling.

20. Admit that a minor's decision making ability is not fully developed.

RESPONSE: Admitted.

21. Admit that minor do not have the mental capacity to consistently make wise decisions about their sexuality.

RESPONSE: Hamilton objects to this request because it is vague and ambiguous because of its use of undefined terms such as "consistently" and "wise." Notwithstanding, Hamilton admits that minors need guidance, advice and counseling to make wise decisions about their sexuality, and further admits that minors should be encouraged to delay sexual activity and sexual identity labels until adulthood.

22. Admit that minors are a particularly vulnerable population.

RESPONSE: Hamilton objects to this request because it is vague and ambiguous because of its use of undefined terms such as "particularly," and because it does not identify any specific vulnerabilities as to which it seeks an admission. Notwithstanding, Hamilton admits that minors can be vulnerable when they lack the protection and support of family, but denies that minors who live in homes with stable, adult parents are necessarily vulnerable.

23. Admit that minors are influenced by their parents or legal guardians.

RESPONSE: Admitted.

24. Admit that minors are typically dependent upon their parents or legal guardians for shelter and provision.

RESPONSE: Admitted.

25. Admit that rejection can harm minors.

OBJECTION/RESPONSE: Hamilton objects to this request because it is vague and ambiguous, in that it fails to define "rejection" or identify any specific types of rejection as to which an admission is sought. Notwithstanding, Hamilton admits that some types of rejection (such as self-rejection) can be harmful to minors, while other types of rejection (such as rejection of harmful or illegal behaviors) can be beneficial to minors. Hamilton therefore denies that all rejection is harmful to minors.

26. Admit that, unless otherwise provided for by law, minors cannot legally consent.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Hamilton further objects to this request because it is vague and ambiguous, in that it does not identify the "consent" as to which an admission is sought, nor does it identify to what "law" it is referring. Notwithstanding, Hamilton denies that minors are always incapable of providing consent.

27. Admit that minors cannot legally consent to therapy that would seek to change their sexual orientation or gender identity.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Hamilton further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Hamilton denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

28. Admit that minors cannot legally consent to therapy that would seek to change their sexual orientation or gender identity without a consenting parent or legal guardian.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Hamilton further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Hamilton admits that, generally, before a minor can voluntarily participate in SOCE counseling, the minor's parent or legal guardian must also give their permission. Hamilton denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

29. Admit that a minor's parent or legal guardian must provide legal consent for any therapeutic treatment of the minor that seeks to change the minor's sexual orientation or gender identity.

OBJECTION/RESPONSE: Hamilton objects to this request because it calls for a legal conclusion. Hamilton further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Hamilton admits that, generally, before a minor can voluntarily participate in SOCE counseling, the minor's parent or legal guardian must also give their permission. Hamilton denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

30. Admit that you have never conducted any therapy that sought to change a minor's sexual orientation or gender identity without the consent of the minor's parent or legal guardian.

RESPONSE: Hamilton admits that she has never conducted any SOCE counseling with a minor without the consent of both the minor and a parent or legal guardian, and without the voluntary, active and willing participation of the minor.

31. Admit that a minor's parents or legal guardian participates in setting the therapeutic goals of your treatment of the minor.

RESPONSE: Hamilton admits that when more than one individual participates in therapy together, each individual identifies the therapeutic goals that individual seeks in therapy. Hamilton further admits that parents or legal guardians approve the therapeutic goals of their minors. To the extent this request implies that a minor's parent or legal guardian can set therapeutic goals for a minor which the minor does not agree with, or that parents or legal guardians can force minors to participate in SOCE counseling against the minor's wishes, Hamilton denies those implications and denies that she would engage in or continue in any SOCE counseling with a minor in such context.

32. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a practice used in your profession.

RESPONSE: Hamilton admits that her "talk therapy" is a practice carried out solely through speech and further admits that characterizing speech as a practice in the effort to label it as conduct is a dubious constitutional enterprise.

33. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a treatment used in your profession.

RESPONSE: Hamilton admits that her "talk therapy" is a form of treatment carried out solely through speech and further admits that characterizing speech as treatment in the effort to label it as conduct is a dubious constitutional enterprise.

34. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a form of mental health counseling.

RESPONSE: Hamilton notes that she is a licensed marriage and family therapist and not a licensed mental health counselor, and that those are two different professional licenses governed by separate professional regulations. Notwithstanding, upon information and belief Hamilton admits that her "talk therapy" may be a form of mental health counseling carried out solely through speech, and further admits that characterizing speech as anything other than speech in the effort to label it as conduct is a dubious constitutional enterprise.

35. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a mental health treatment or procedure.

RESPONSE: Hamilton admits that her "talk therapy" is a form of treatment carried out solely through speech and further admits that characterizing speech as treatment or procedure in the effort to label it as conduct is a dubious constitutional enterprise.

36. Admit that you wish to conduct therapeutic practices that seek to change a minor's sexual orientation.

OBJECTION/RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Hamilton denies that she seeks to conduct any therapeutic practice that pursues any goals other than those identified by the client, which a client willingly and actively pursues.

37. Admit that you wish to conduct therapeutic practices that seek to change a minor's gender identity.

OBJECTION/RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Hamilton denies that she seeks to conduct any therapeutic practice that pursues any goals other than those identified

by the client, which a client willingly and actively pursues.

38. Admit that, since the passage of the County's ordinance 2017-046, you have provided information regarding "conversion therapy," as it is defined in the County's ordinance, outside of the counselling [*sic*] or therapy setting.

OBJECTION/RESPONSE: Hamilton objects to this request because it is vague and ambiguous in that it fails to define what "information regarding 'conversion therapy'" means, and fails to identify with reasonable specificity the "information" as to which an admission is sought. Hamilton further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. This lawsuit is about constitutionally protected speech that the ordinance prohibits, and not about constitutionally protected speech that the ordinance permits. Notwithstanding, Hamilton admits that she has spoken to individuals outside of counseling or therapy sessions concerning certain aspects of her practice of licensed marriage and family therapy and about the ordinance itself.

39. Admit that you have provided therapy that sought to change the patient's sexual orientation to a patient under the age of 5.

RESPONSE: Denied.

40. Admit that you have provided therapy that sought to change the patient's sexual orientation to a patient under the age of 10.

RESPONSE: Denied.

41. Admit that you have provided therapy that sought to change the patient's gender identity to a patient under the age of 5.

RESPONSE: Denied.

42. Admit that you have provided therapy that sought to change the patient's gender identity to a patient under the age of 10.

RESPONSE: Hamilton objects to this request because it fails to identify a relevant time period. Hamilton further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. To the extent the request implies that Hamilton has provided therapy that sought any goals other than those identified by the client, which the client willingly and actively pursued, Hamilton denies the implication and denies the request. Notwithstanding, Hamilton admits that, prior to the enactment of ordinance 2017-046, she provided counseling aimed at

helping a child under the age of 10 be more comfortable with his or her biological sex, and states that, in such cases, the majority of session time was spent with the parents, with some of the session time being spent with the child, depending on the age of the child.

43. Admit that your religion does not require you to conduct therapeutic practices that seek to change a minor's sexual orientation.

OBJECTION/RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Hamilton denies that her religion does not require her to assist her patients in living according to their sincerely held religious beliefs, including in matters relating to human sexuality and sexual attractions and behaviors.

44. Admit that your religion does not require you to conduct therapeutic practices that seek to change a minor's gender identity.

OBJECTION/RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Hamilton denies that her religion does not require her to assist her patients in living according to their sincerely held religious beliefs, including in matters relating to human sexuality and sexual attractions and behaviors.

45. Admit that County's [sic] ordinance 2017-046 does not reference any religion.

RESPONSE: Denied.

46. Admit that County's [sic] ordinance 2017-046 does not reference any religious practice or conduct.

RESPONSE: Denied.

47. Admit that you cannot change a minor's sexual orientation.

RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Hamilton denies the implication that a minor's sexual orientation is rigid and unchangeable, denies that a minor's sexual orientation can never change, and denies that Hamilton cannot safely and effectively assist minors in understanding themselves and making the changes that the minors desire for their lives.

48. Admit that you cannot change a minor's gender identity.

RESPONSE: Hamilton objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Hamilton further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Hamilton denies the implication that a minor's gender identity is rigid and unchangeable, denies that a minor's gender identity can never change, and denies that Hamilton cannot safely and effectively assist minors in understanding themselves and making the changes that the minors desire for their lives.

49. Admit that psychological harms may take years to manifest of be identified.

RESPONSE: Hamilton objects to this request because it is vague and ambiguous, in that it fails to specify the "psychological harms" as to which an admission is sought. Notwithstanding, Hamilton admits that some psychological harms – like the harms being inflicted by the County's Ordinance 2017-046 on the minors it deprives of the counseling and assistance they seek – make take years to be fully manifested or understood.

50. Admit that it is unethical to perform therapeutic practices that may harm a minor.

RESPONSE: Hamilton objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Hamilton admits that it is unethical to purposefully harm minors in therapy, but Hamilton denies the implication and premise of this request that voluntary SOCE counseling that is consistent with a minor's goals and beliefs, and that a minor seeks and willingly receives, can be harmful to that minor. Hamilton further denies that any study has ever found that voluntary SOCE counseling that is consistent with a minor's goals and beliefs, and that a minor seeks and willingly receives, can be harmful to that minor. Hamilton admits that withholding voluntary, client-directed SOCE counseling from willing minors, or forcing gay- or transgender- affirming therapy on minors who do not wish to receive or for whom such therapy conflicts with their goals, desires and beliefs, is extremely harmful and therefore unethical.

/s/ Horatio G. Mihet
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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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/s/ Horatio G. Mihet
Horatio G. Mihet

Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF JULIE H. HAMILTON, PH.D., LMFT'S FIRST SUPPLEMENTAL OBJECTIONS AND RESPONSES TO THE PRELIMINARY INJUNCTION INTERROGATORIES OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 33, and Local Rule 26.1, Plaintiff Julie H. Hamilton, Ph.D., LMFT ("Hamilton"), by and through counsel, hereby provides the following First Supplemental responses and objections to Defendant County of Palm Beach's Preliminary Injunction Interrogatories. Hamilton hereby reserves all objections to the relevance, use or admissibility of any of these Interrogatories and responses. Subject to the foregoing, Hamilton objects and otherwise responds as follows:

18. In the year prior to the passage of the County's ordinance at issue, what percentage of your practice involved counseling that sought to change a minor's gender identity of [*sic*] sexual orientation and what percentage of your counseling sought to assist a minor in embracing or coping with a non-heterosexual orientation or a gender identity that differed from their anatomical sex?

RESPONSE: As stated in response to Interrogatory No. 17, Hamilton has not had clients who sought assistance in coping with wanted same-sex attractions or wanted gender identity that is different from anatomical sex, because the clients, who were not seeking change, stated that they were already embracing a non-heterosexual identity or transgender identity. As such, Hamilton was not presented with a client who stated that his or her goal

was to be able cope with an attraction or identity that differed from their own concept of self.

Also as stated in response to other Interrogatories (*e.g.*, Interrogatory 9), Hamilton does not try to change her clients' sexual orientation or gender identity. Hamilton's practice deals only with assisting clients achieve their own goals, addressing the issues the clients wish to address, and focusing solely on the clients' needs.

In the year prior to the passage of the Ordinance, Hamilton worked with a total of 44 different clients (individuals, couples or families). Out of these, 36 clients were couples, families or individuals that did not include minors seeking SOCE counseling. Of the remaining 8 clients, 5 were minors requesting help for unwanted same-sex attractions or gender identity issues. The other 3 were minors who wanted to embrace their homosexual attractions or transgender identity. These 3 minors did not seek assistance in dealing with, or embracing, their homosexual attractions or gender identity, but sought help with different goals, such as helping their parents cope with these issues, or working on other family issues.

As to Objections:

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VERIFICATION

I, Julie H. Hamilton, Ph.D., LMFT, declare under penalty of perjury under the laws of the United States of America that the foregoing interrogatory responses are true and correct.

/s/ Julie H. Hamilton
Julie H. Hamilton, Ph.D., LMFT

CERTIFICATE OF SERVICE

I hereby certify that on this 27th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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Horatio G. Mihet

Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF ROBERT W. OTTO, PH.D., LMFT'S OBJECTIONS AND RESPONSES TO THE PRELIMINARY INJUNCTION INTERROGATORIES OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 33, and Local Rule 26.1, Plaintiff Robert W. Otto, Ph.D., LMFT ("Otto"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Interrogatories. Otto hereby reserves all objections to the relevance, use or admissibility of any of these Interrogatories and responses. Subject to the foregoing, Otto objects and otherwise responds as follows:

1. Please state the name and address of the person or persons answering these interrogatories and if applicable the official position or relationship with the party to whom the interrogatories are directed.

RESPONSE: The person providing the substantive information disclosed in these interrogatory responses, and verifying them under oath, is Plaintiff Robert W. Otto, who may be contacted through his undersigned counsel. The objections to these interrogatories are made by the undersigned counsel.

2. Explain the legal basis for your assertion that a minor can legally undergo gender reassignment surgery and breast augmentation without the consent of a parent or legal guardian.

OBJECTION: Otto objects to this Interrogatory because it misstates Otto's positions. Otto further objects to this interrogatory because it expressly calls for a legal conclusion. Otto is not a lawyer. The "legal basis" for his positions is provided by his counsel in briefs, and is not a proper subject of interrogatories to Otto.

3. Describe in detail everything you included when you sought the informed consent of a minor to conduct any therapeutic practice that seeks to change the minor's sexual orientation or gender identity.

OBJECTIONS: Otto objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Otto's speech or conduct after the enactment of the Ordinance in suit, Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance. Otto will therefore respond to the Interrogatory as if limited to his speech or conduct prior to the enactment of the Ordinance.

Otto further objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail everything" he says or does on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to what Otto generally says or does, or wishes to say or do, on the requested topic. To the extent Otto provides examples, they are not exhaustive or inclusive of "everything" Otto says or does, or wishes to say or do, in every context. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Otto notes that the way this Interrogatory is worded implies that sexual orientation is a fixed concept that he is trying to change. Otto objects to that characterization as misleading and disagrees with the Interrogatory's premise, assumption and articulation of the issue. Otto notes that his marriage and family therapy practice is focused solely on helping a client achieve his or her stated goals, not a preconceived notion that he "seeks" to change behaviors, thoughts or feelings. Otto focuses on the issues that the client wants to address, including those situations where clients seek assistance in conforming their identity and attractions to their sincerely held religious beliefs, values, and concept of self.

For the Informed Consent Form for Counseling Regarding Unwanted Same-Sex Attractions and Behaviors, which Otto has adopted for clients of his practice, SDG Counseling, LLC, see Otto 008-009, produced in response to the County's Requests for Production.

4. Describe in detail everything you included when you sought the informed consent of a minor to conduct any therapeutic practice that seeks to reduce or eliminate "unwanted same-sex attractions or behaviors."

OBJECTIONS: Otto objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Otto's speech or conduct after the enactment of the Ordinance in suit, Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance. Otto will therefore respond to the Interrogatory as if limited to his speech or conduct prior to the enactment of the Ordinance.

Otto further objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail everything" he says or does on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to what Otto generally says or does, or wishes to say or do, on the requested topic. To the extent Otto provides examples, they are not exhaustive or inclusive of "everything" Otto says or does, or wishes to say or do, in every context. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Otto notes that the way this Interrogatory is worded implies that sexual orientation is a fixed concept that he is trying to change. Otto objects to that characterization as misleading and disagrees with the Interrogatory's premise, assumption and articulation of the issue. Otto notes that his marriage and family therapy practice is focused solely on helping a client achieve his or her stated goals, not a preconceived notion that he "seeks" to change behaviors, thoughts or feelings. Otto focuses on the issues that the client wants to address, including those situations where clients seek assistance in conforming their identity and attractions to their sincerely held religious beliefs, values, and concept of self.

For the Informed Consent Form for Counseling Regarding Unwanted Same-Sex Attractions and Behaviors, which Otto has adopted for clients of his practice, SDG

Counseling, LLC, see Otto 008-009, produced in response to the County's Requests for Production.

5. Describe in detail everything you wish to be able to say outside of a therapy session that you contend is prohibited by the County's ordinance.

OBJECTIONS: Otto objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail everything" he wishes to say or do on the requested subject. This is impossible to do in an interrogatory response, particularly where the Interrogatory purports to ask about every situation "outside of a therapy session" that Otto would ever find himself in, or every speech, communication, presentation or interaction "outside of a therapy session" that Otto would ever participate in. Otto will therefore respond to the Interrogatory as if limited to what Otto generally might wish to say in some instances outside of a formal therapy session. To the extent Otto provides examples, they are not exhaustive or inclusive of "everything" Otto wishes to say in every context. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

Otto further objects to this Interrogatory because it calls for a legal conclusion. Otto is not a lawyer, but will provide his understanding of how the Ordinance, which is vague and ambiguous, appears to work in some instances.

RESPONSE: Otto notes that, according to the Ordinance, so-called "conversion therapy" – which Otto has never used to describe his practice and knows of no other licensed mental health professional who employs such term – means "the practice of seeking to change an individual's sexual orientation or gender identity, including but not limited to efforts to change behaviors, gender identity, or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender or sex." Otto notes that the Ordinance also states that, "It shall be unlawful for any Provider to engage in conversion therapy on any minor regardless of whether the Provider receives monetary compensation in exchange for such services."

Otto is left to guess at any number of situations in which these provisions would prohibit him from discussing certain issues outside of a formal therapy session. Based on the Ordinance, as a licensed provider, Otto is not permitted to attempt to help a minor with changes the minor wishes to make, even if he is not getting paid. Even if Otto is outside of his counseling office, and merely talking to or trying to help a friend's son or daughter address their unwanted same-sex attractions, behaviors, identity, or gender confusion, the Ordinance would prohibit that kind of speech. Under the Ordinance, Otto also notes that such a restriction would apply to conversations he would have with his own grandchild or with other minors in his extended family or network of friends.

The Ordinance prohibits "the practice of seeking to change," which in Otto's field consists of conversations between him and those whom he is trying to help. Therefore, the Ordinance prohibits Otto from even having conversations that would seek to help minors

with changes they wish to make in the areas prohibited by the Ordinance, even if he is outside the office, not getting paid for such help. Otto also notes that such a broad prohibition may even apply to him giving lectures, speeches, or lessons at a church or local organization that desires to assist parents and children who are struggling with such issues.

Otto would also like to be able to advertise his services to minors who seek to reduce or eliminate their unwanted same-sex attractions, behaviors, identity, or gender confusion (and their parents). Otto would like to be able to advertise on websites, through radio, in published print, in brochures, through verbal communications, and via other mechanisms to offer his services in this area. Because of the Ordinance, however, Otto is prohibited from distributing such advertisements because he cannot advertise something that he is not legally permitted to offer.

6. Describe in detail everything you wish to be able to say in therapy to a minor patient that you contend is prohibited by the County's ordinance.

OBJECTIONS: Otto objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail everything" he wishes to say or do on the requested subject. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to what Otto generally might wish to say in some instances in a therapy session with a minor. To the extent Otto provides examples, they are not exhaustive or inclusive of "everything" Otto wishes to say in every context. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

Otto further objects to this Interrogatory because it calls for a legal conclusion. Otto is not a lawyer, but will provide his understanding of how the Ordinance, which is vague and ambiguous, appears to work in some instances.

RESPONSE: Otto contends that the Ordinance is prohibiting him from saying anything that might possibly be construed, understood, or inferred to be seeking to help a minor reduce or eliminate unwanted same-sex attractions, behaviors, or identity or gender confusion, even when such statements are not uttered with the express aim of changing a minor's sexual orientation or gender identity. Otto notes that he does not engage in therapy where his goal is to change any client's sexual orientation or gender identity, but that he seeks to help clients achieve the goals that the clients themselves determine are appropriate for them. Under the Ordinance, not only is Otto prohibited from engaging in such talk therapy with his clients, but his clients are prohibited from even having certain goals in the therapeutic alliance, even when those goals are necessary for the clients to live consistently with their sincerely held religious beliefs, values, and concept of self.

Otto cannot possibly describe in this response every potential issue or statement that he might like to address in a therapeutic setting because his talk therapy practice is never the same for every client. Otto's practice focuses on conversations and discussions that address

what the clients present with, what the clients wish to explore or address, and the goals and aims that the clients wish to pursue.

Some examples of what Otto is prohibited from discussing in his practice include the following: talking about a minor client's unwanted, non-heterosexual sexual behaviors, thoughts, or feelings; conversations concerning the origins of the client's unwanted feelings; conversations concerning potential causes of such unwanted feelings, such as social information, experiences, and potential abuse; and conversations concerning the client's religious beliefs and how the client's unwanted attractions or feelings collide with those religious beliefs.

Otto would like to be able to discuss family and other support available to the client. He would talk about how the client has dealt with unwanted same-sex attractions or feelings to date, about setting up boundaries to assist the client make the choices the client wants to make, and about triggers. Otto would like to talk about what goals the client has for this area of life, including any changes to specific behaviors or thoughts that the client may see as problematic. Otto would like to talk about how adolescent brain development impacts a teen's ability to make rational decisions rather than emotional decisions. Otto would like to talk about different feelings that people may have but choose not to act upon. Otto would also like to talk about how people sometimes use sex, relationships and pornography to medicate or cope with uncomfortable feelings. Otto would also like to talk about neurochemistry and how that plays a part in sexuality.

Because of the Ordinance, Otto cannot discuss any of these issues or topics in therapy sessions with minors, because they may lead to change or may be construed as "efforts to change."

7. Describe in detail what "talk therapy" practices you employed, prior to the passage of the County's ordinance, to reduce or eliminate same-sex attractions. Specify what concepts and information you communicated as "truth," what advice was generally given, and what tools you generally recommended the minor employ.

OBJECTIONS: Otto objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail" the therapy he provided and advice he gave to every SOCE counseling client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to Otto's general approach to talk therapy with same-sex attracted clients prior to the enactment of the Ordinance. To the extent Otto provides examples, they are not exhaustive or inclusive of everything Otto said or did in such therapy sessions. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Otto incorporates his response to Interrogatory 6 to illustrate the general nature of his talk therapy sessions with same-sex attracted clients prior to the enactment of the Ordinance.

As to the question related to "truth," Otto notes that approximately 90 percent of his clients profess to be Bible-believing Christians with sincerely held religious beliefs that the Bible is the source of all truth. Otto shares those beliefs and therapy sessions sometimes include discussion of Biblical truths, including that God created men and women, that they are distinctly different, and that their design was purposeful. Otto's Christian, Jewish, and Muslim clients all hold the same sincerely held religious beliefs as Otto in this area.

Otto sometimes also conveys the biological truth that male and female bodies are different even down the individual cell level. Otto sometimes shares that every cell in man's body has an X and a Y chromosome, and every cell in the female body has 2 X chromosomes (with the only exception being the sperm and egg cells which only have one chromosome). Otto sometimes discusses neuro-chemistry and its impact on human sexuality.

8. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the efficacy of the therapy you describe in your answer to interrogatory number 7 above.

OBJECTION/RESPONSE: Otto objects to this Interrogatory on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible article, research paper, report, etc. that supports the use of client-centered therapy. Construing this Interrogatory as limited to those articles, research papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response: See PLJoint 081-793 produced in response to the County's Requests for Production.

9. Describe in detail what "talk therapy" practices you employed, prior to the passage of the County's ordinance, to seek to change a minor's sexual orientation or gender identity. Specify what concepts and information you communicated as "truth," what advice was generally given, and what tools you generally recommended the minor employ.

OBJECTIONS: Otto objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail" the therapy he provided and advice he gave to every SOCE counseling client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to Otto's general approach to talk therapy with same-sex attracted clients and gender confused clients prior

to the enactment of the Ordinance. To the extent Otto provides examples, they are not exhaustive or inclusive of everything Otto said or did in such therapy sessions. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Otto incorporates his responses to Interrogatories 6 and 7 to illustrate the general nature of his talk therapy sessions with same-sex attracted clients prior to the enactment of the Ordinance.

Otto has not found it helpful to discuss sexual orientation as a concept in itself during therapy sessions. He notes that sexual orientation is not a behavior, thought, or feeling, and that labeling such behaviors, thoughts, and feelings with the "sexual orientation" label presupposes that such a trait is fixed and immutable, which the scientific literature does not support. Both the research Otto has reviewed and his own experience in his practice confirms that such a fixed and immutable description is not accurate.

Otto further responds that he has not yet had clients present issues related to gender identity or gender identity confusion.

10. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the efficacy of the therapy you describe in your answer to interrogatory number 9 above.

OBJECTION/RESPONSE: Otto incorporates by reference, as if fully restated herein, his Objection/Response to Interrogatory 8.

11. Describe in detail what you tell minors in therapy, as part of your therapeutic practice, are the root causes of their "unwanted same-sex attractions, behaviors, and identity."

OBJECTIONS: Otto objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Otto's speech or conduct after the enactment of the Ordinance in suit, Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance. Otto will therefore respond to the Interrogatory as if limited to his speech or conduct prior to the enactment of the Ordinance.

Otto further objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail" what he has told every SOCE counseling

minor client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to Otto's general approach to talk therapy with same-sex attracted clients and gender confused clients prior to the enactment of the Ordinance. To the extent Otto provides examples, they are not exhaustive or inclusive of everything Otto said or did in such therapy sessions. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: According to the research, there is no conclusive information about the root causes of unwanted same-sex attractions, behaviors, and identity. According to the APA, both nature and nurture play a role. According to the APA Handbook on Sexuality and Psychology (2014), there may be a link between lack of a same-sex parent and later homosexuality. The authors of various studies have also described a possible correlation between sexual abuse and homosexuality.

In his practice, depending on the needs of his individual clients, Otto generally discusses several things that can serve as contributing factors to a client's unwanted same-sex attractions, behaviors, and identity, such as societal influences, peers, peer influences, abuse, parenting issues, parent and child relationship issues, trauma, and curiosity. Otto discusses with his clients that there is no research that can point to one single "root cause" of an individual's unwanted same-sex attractions, behaviors, or identity, but notes that the research does not support the commonly proclaimed myth that people are "born gay."

12. Describe in detail what you tell minors in therapy, as part of your therapeutic practice, about gender roles and identities.

OBJECTIONS: Otto objects to this Interrogatory on the ground that it fails to specify a time period. To the extent the Interrogatory purports to request information about Otto's speech or conduct after the enactment of the Ordinance in suit, Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance. Otto will therefore respond to the Interrogatory as if limited to his speech or conduct prior to the enactment of the Ordinance.

Otto further objects to this Interrogatory because it inappropriately calls for a narrative response and requires him to "describe in detail" what he has told every SOCE counseling minor client prior to the enactment of the Ordinance. This is impossible to do in an interrogatory response, particularly in the context of the client-driven and client-centered therapy he practices, where no two interactions are exactly alike. Otto will therefore respond to the Interrogatory as if limited to Otto's general approach to talk therapy with

same-sex attracted clients and gender confused clients prior to the enactment of the Ordinance. To the extent Otto provides examples, they are not exhaustive or inclusive of everything Otto said or did in such therapy sessions. Otto is prepared to supplement his response with deposition testimony, and otherwise as appropriate in discovery.

RESPONSE: Otto notes that approximately 90 percent of his clients profess to be Bible-believing Christians with sincerely held religious beliefs that the Bible is the source of all truth, including on matters of gender roles. Otto shares those beliefs and therapy sessions sometimes include discussion of Biblical truths, including that God created men and women, that they are distinctly different, and that their design was purposeful. Otto's Christian, Jewish, and Muslim clients all hold the same sincerely held religious beliefs as Otto in this area. Otto's conversations in this area have involved speaking of gender roles and a client's identity from a Christian perspective and viewpoint, specifically looking at what the Bible says on such matters.

13. Describe the principles and methods of the "talk therapy" practices you wish to use but claim that you cannot because of the passage of the County's ordinance.

OBJECTION/RESPONSE: Otto incorporates by reference, as if fully restated herein, his Objections and Responses to Interrogatories 6, 7 and 9.

In addition, Otto states that, because the Ordinance is vague and ambiguous, he does not know how the County is interpreting and applying it, and he does not know the full extent of what the Ordinance prohibits. In essence, the Ordinance prohibits Otto from assisting his minor clients in accomplishing the goals they have for their lives, many of which arise because of their sincerely held religious beliefs, values, and concept of self. Some of his clients' goals are no longer permissible under the Ordinance. The County has taken away the fundamental right of certain clients to self-determination in that they cannot have the goals of changing homosexual behaviors, seeking to understand and thereby diminish, if possible, homosexual attractions; and becoming more secure in their biological sex when their gender identity does not match their biological sex.

14. Describe the principles and methods of the "talk therapy" practices that can reduce or eliminate same-sex attractions.

OBJECTION/RESPONSE: Otto incorporates by reference, as if fully restated herein, his Objections and Responses to Interrogatories 6, 7 and 9.

15. Describe the principles and methods of the "talk therapy" practices that can change a minor's sexual orientation or gender identity.

OBJECTION/RESPONSE: Otto incorporates by reference, as if fully restated herein, his Objections and Responses to Interrogatories 6, 7 and 9.

16. Identify the author(s), title, publication date, journal, publisher and location of all articles, research papers, or reports that support or substantiate the conclusion that unwanted same-sex attractions result from trauma.

OBJECTION/RESPONSE: Otto objects to this Interrogatory on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible article, research paper, report, etc. that supports the correlation between unwanted same-sex attractions and sexual abuse or trauma. Construing this Interrogatory as limited to those articles, research papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response:

Dr. Lawrence S. Mayer and Dr. Paul R. McHugh, "Sexuality and Gender: Findings from a Biological, Psychological, and Social Sciences." The New Atlantis, Fall 2016, https://www.thenewatlantis.com/publications/number-50-fall-2016

Friedman, M.S., Marshal, M.P., Guadamuz, T.E., et. al. "A Meta-Analysis of Disparities in Childhood Sexual Abuse, Parental Physical Abuse, and Peer Victimization Among Sexual Minority and Sexual Nonminority Individuals." American Journal of Public Health, August 2011, https://ajph.aphapublications.org/doi/10.2105/AJPH.2009.190009

17. Have you ever counseled a minor to assist them in coping with wanted same-sex attractions? If so, please identify how many minors you have so helped in the last 5 years.

RESPONSE: Otto has not counseled a minor seeking to cope with wanted same-sex attractions. Otto is a Christian counselor. He has worked at a Christian counseling center on the campus of a Christian church. He has marketed his services via Christian friends, churches, Christian schools, and doctors and lawyers who are Christians. Most of Otto's clients share the same Christian convictions or are at least comfortable working from this framework. If a client was looking for help becoming comfortable with same-sex attractions, Otto would refer that client to professionals who would be better able to help, as is common in his profession.

18. In the year prior to the passage of the County's ordinance at issue, what percentage of your practice involved counseling that sought to change a minor's gender identity of [*sic*] sexual orientation and what percentage of your counseling sought to assist a minor in embracing or coping with a non-heterosexual orientation or a gender identity that differed from their anatomical sex?

RESPONSE: Otto has not had a client present with issues related to gender identity or gender identity confusion. As to minors who present with stated goals to conform their sexual attractions, behaviors, or identity to their sincerely held religious beliefs, values, or concept of self, in a typical year prior to the enactment of the Ordinance they accounted for a small part (approximately five percent) of Otto's practice.

19. Explain with specificity and in detail (a) the decline in profit your practice has sustained since or as a result of the passage of the County's conversion-therapy ban ordinance at issue; (b) identify the actual dollar amount of the decline in profit; (c) and identify the specific methodology you utilized to compute (a) and (b) above.

OBJECTION: Otto objects to this Interrogatory on the grounds that it is premature. The Preliminary Injunction Hearing is concerned exclusively with the irreparable and incalculable harm that the unconstitutional Ordinance is imposing on Otto and his clients each and every day it remains in effect, by virtue of its indiscriminate ban on constitutionally protected speech, and its violation of other constitutional liberties. This is the primary harm this lawsuit seeks to redress. Accordingly, it is not proper for "Preliminary Injunction Interrogatories" to request a calculation of money damages. Otto does not seek money damages at the Preliminary Injunction Hearing.

In the subsequent merits and damages phase of discovery following the Preliminary Injunction Hearing, Otto will attempt to calculate his lost revenues and profits from the clients he has had to turn away following enactment of the Ordinance, and will provide same to Defendants, provided Defendants stipulate that such disclosure does not amount to any waiver of Otto's Fifth Amendment Privilege with respect to any other information. To the extent lost revenues and profits from clients turned away on account of the Ordinance can be calculated, they would constitute only a portion of the harm suffered by Otto and his clients, and they could not make Otto or his clients whole for the irreparable harm imposed by the Ordinance.

20. Identify by first and last initial and age only all minor clients with whom you completely terminated your professional relationship because of the passage of the County's ordinance at issue and the date of the termination.

OBJECTION: Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance.

Otto further objects to this interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks him to divulge too much identifying information regarding his clients.

Otto is willing to provide the number of "Doe" clients or potential clients, and their ages, whom he has had to turn away, or for whom he has had to alter the scope of therapy on account of the Ordinance, but only if Defendants stipulate that such disclosure does not amount to any waiver of Otto's Fifth Amendment Privilege, or the psychotherapist-patient privilege, with respect to any other information.

21. Identify by first and last initial and age only all minor clients with whom you substantially changed your professional relationship because of the passage of the County's ordinance at issue.

OBJECTION: Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance.

Otto further objects to this interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks him to divulge too much identifying information regarding his clients.

Otto is willing to provide the number of "Doe" clients or potential clients, and their ages, whom he has had to turn away, or for whom he has had to alter the scope of therapy on account of the Ordinance, but only if Defendants stipulate that such disclosure does not

amount to any waiver of Otto's Fifth Amendment Privilege, or the psychotherapist-patient privilege, with respect to any other information.

22. Identify by first and last initial and age only all clients whom were minors (under age 18) when they initially engaged your counseling services that are or were experiencing unwanted same-sex attractions and wanted to reduce or eliminate the unwanted desire within the last ten years.

OBJECTION: To the extent the Interrogatory purports to request information about Otto's minor clients after the enactment of the Ordinance in suit, Otto objects and declines to respond on the basis of the Fifth Amendment privilege against self-incrimination. Although Otto has been forced to alter his speech and conduct after the enactment of the Ordinance in order to avoid a knowing violation, Otto notes that the Ordinance is not only vague and ambiguous in what it purports to prohibit, but also purports to impose criminal penalties for any violation, whether knowing or unknowing. Accordingly, Otto does not wish to provide the County with any information upon which to prosecute him for any unknowing violations of the Ordinance. Otto will therefore respond to the Interrogatory as if limited to the nine (9) years prior to the enactment of the Ordinance.

Otto further objects to this Interrogatory on the grounds that it seeks information protected by the psychotherapist-patient privilege and that it asks him to divulge too much identifying information in relation to these clients. Otto construes this Interrogatory to only request the number and approximate ages of clients seeking help for unwanted same-sex attractions.

RESPONSE: In the nine (9) years prior to the enactment of the Ordinance, Otto had the following minor clients who sought help with unwanted same-sex attractions:

Doe 1 (high school student)
Doe 2 (high school student)
Doe 3 (high school student)
Doe 4 (high school student)

23. Do you admit that therapy you wish to provide is a mental health treatment? If not, please explain why.

RESPONSE: Otto admits that the SOCE counseling he wishes to provide to the minor clients who seek and desire it is a form of treatment carried out solely through speech, and agrees with the Eleventh Circuit Court of Appeals that characterizing speech as treatment or procedure in an effort to afford it less First Amendment protection is a dubious constitutional enterprise.

24. Do you admit that therapy you wish to provide is professional conduct? If not, please explain why.

RESPONSE: Otto denies that the SOCE counseling he wishes to provide to the minor clients who seek and desire it is professional conduct, and agrees with the Eleventh Circuit Court of Appeals that characterizing speech as conduct in an effort to afford it less First Amendment protection is a dubious constitutional enterprise.

As to Objections:

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VERIFICATION

I, Robert W. Otto, Ph.D., LMFT, declare under penalty of perjury under the laws of the United States of America that the foregoing interrogatory responses are true and correct.

/s/ Robert W. Otto
Robert W. Otto, Ph.D., LMFT

CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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Horatio G. Mihet

Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF ROBERT W. OTTO, PH.D., LMFT'S RESPONSES AND OBJECTIONS TO THE PRELIMINARY INJUNCTION REQUESTS TO PRODUCE OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 34, and Local Rule 26.1, Plaintiff Robert W. Otto, Ph.D., LMFT ("Otto"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Requests to Produce. Otto hereby reserves all objections to the relevance, use or admissibility of any of these requests and responses, or the responsive documents being produced. Subject to the foregoing, Otto objects and otherwise responds as follows:

1. A copy of your resume or curriculum vitae.

RESPONSE: See Otto 001.

2. A copy of all publications, presentations, studies, research papers, or reports you have created or authored on the subject of sexual orientation or gender identity.

RESPONSE: After a reasonable search, Otto has determined that he does not have any responsive documents in his custody, possession or control.

3. A copy of your fee schedule, contract, or hourly charges for the type of services you claim you can no longer practice because of the County's ordinance.

RESPONSE: See Otto 002.

4. A blank copy of the "extensive informed consent form" referenced in paragraph 128 of the Complaint.

RESPONSE: See Otto 003-009.

5. A copy of all Codes of Ethics relating to the regulations mental health professionals and counselors, including Licensed Marriage and Family Therapists.

RESPONSE: See PLJoint 001-080. See also Fla. Stat. Ann. § 491.009; and Fla. Admin. Code § 64B4-5.001.

6. A copy of all studies, research papers, or reports that support or substantiate the efficacy of any practice that seeks to change the sexual orientation of a minor.

OBJECTION/RESPONSE: Otto objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response: See PLJoint 081-793.

7. A copy of all studies, research papers, or reports that support or substantiate the efficacy of any practice that seeks to change the gender identity of a minor.

OBJECTION/RESPONSE: Otto objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response: See PLJoint 081-793.

8. A copy of all studies, research papers, or reports that support or substantiate the efficacy of any practice that seeks to reduce or eliminate same-sex attractions or feelings of a minor.

OBJECTION/RESPONSE: Otto objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response: See PLJoint 081-793.

9. A copy of all studies, research papers, or reports that support or substantiate the benefit of sexual orientation change efforts in minors.

OBJECTION/RESPONSE: Otto objects to this request on the grounds that it is overbroad, unduly burdensome, and impracticable, as it would call for a virtually endless production of every possible study, paper, report, etc. that supports the use of client-centered therapy. Construing this request as limited to those studies, papers, and reports that Otto has reviewed, gained some personal insight from, and recalls as of the time of this response, Otto provides the following response: See PLJoint 081-793.

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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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Horatio G. Mihet

Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,	)	Civil Action No.:9:18-cv-80771-RLR
Plaintiffs,	)	**INJUNCTIVE RELIEF SOUGHT**
v.	)	
CITY OF BOCA RATON, FLORIDA, and COUNTY OF PALM BEACH, FLORIDA,	)	
Defendants	)	

PLAINTIFF ROBERT W. OTTO, PH.D., LMFT'S RESPONSES AND OBJECTIONS TO THE PRELIMINARY INJUNCTION REQUESTS FOR ADMISSION OF DEFENDANT PALM BEACH COUNTY

Pursuant to Fed. R. Civ. P. 26 and 36, and Local Rule 26.1, Plaintiff Robert W. Otto, Ph.D., LMFT ("Otto"), by and through counsel, hereby provides the following responses and objections to Defendant County of Palm Beach's Preliminary Injunction Requests for Admission. Unless specifically admitted, each Request or part thereof is hereby DENIED. Any and all admissions are subject to the qualifications and conditions stated in the response containing that admission, and subject to any stated objections. Otto hereby reserves all objections to the relevance, use or admissibility of any of these requests and responses. Subject to the foregoing, Otto admits, denies, objects and otherwise responds as follows:

1. Admit that you practice your profession exclusively within the city limits of the City of Boca Raton.

RESPONSE: Denied.

2. Admit that your professional conduct is subject to government regulation.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Notwithstanding, Otto admits that his professional conduct is subject to government regulation at the state level by the State of Florida Department of Business and Professional Regulation, which licenses and regulates the practice of mental health professions within legal and constitutional boundaries. Otto denies that his professional conduct is subject to regulation by local (county or city) governments.

3. Admit that local governments have the power to regulate ineffective medical and mental health treatments.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Notwithstanding, Otto denies that local governments have the power to regulate medical and mental health treatments.

4. Admit that local governments have the power to regulate harmful medical and mental health treatments.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Notwithstanding, Otto denies that the local governments have the power to regulate medical and mental health treatments.

5. Admit that Palm Beach County has the police power to regulate the practice of professions.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Notwithstanding, Otto denies that Palm Beach County has the power to regulate licensed professionals in the conduct or practice of their profession.

6. Admit that Palm Beach County has the police power to legislate in the interest of protecting the physical and psychological well-being of minors.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Notwithstanding, Otto admits that Palm Beach County has the power to legislate in the interest of protecting the well-being of minors, but only to the extent such legislation is authorized under the Florida Constitution and statutes, and only if such legislation does not violate statutory or constitutional protections.

7. Admit that protecting the physical and psychological well-being of minors is a legitimate government interest.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Otto admits that protecting the well-being of minors from provable serious or fatal harm is a legitimate government interest. Otto otherwise denies this request.

8. Admit that Palm Beach County has a compelling interest in protecting the physical and psychological well-being of minors.

OBJECTION/RESPONSE: Otto objects to this request to because it calls for a legal conclusion. Notwithstanding, Otto admits that protecting the well-being of minors from provable serious or fatal harm is a compelling government interest. Otto otherwise denies this request.

9. Admit that protecting the integrity and ethics of medical and mental health professions in a legitimate government interest.

OBJECTION/RESPONSE: Otto objects to this request because it calls of a legal conclusion. Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Otto admits that protecting the integrity and ethics of medical and mental health professions, subject to constitutional and statutory protections, is a legitimate government interest for those governmental bodies constitutionally and statutorily empowered to regulate such professions, in this case the State of Florida and its agencies. Otto denies that protecting the integrity and ethics of medical and mental health professions is a legitimate interest of local governments.

10. Admit that Palm Beach County has a compelling interest in protecting the integrity and ethics of medical and mental health professions.

OBJECTION/RESPONSE: Otto objects to this request because it calls of a legal conclusion. Notwithstanding, Otto denies this request.

11. Admit that a government's authority over minors' activities is broader than like actions of adults.

OBJECTION/RESPONSE: Otto objects to this request because it calls of a legal conclusion. Otto further objects to this request because it is vague and ambiguous in that it fails to specify the "activities" as to which it seeks an admission or the level or branch of "government" to which it refers. Notwithstanding, Otto admits that, subject to constitutional and statutory protections, an appropriate government body may regulate certain activities of minors, such as driving, smoking or drinking, to a greater extent than it can for adults. Otto denies that any government body can exceed its proper authority, violate or intrude upon the parent-child relationship, override the parents' duty or responsibility to direct the upbringing of their children, or otherwise violate the statutory or constitutional rights of minors or adults.

12. Admit that being lesbian, gay, bisexual, or transgender is not a mental disease.

OBJECTION/RESPONSE: Otto objects to this request because it is compound. Otto further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental disease." Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Otto admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

13. Admit that being lesbian, gay, bisexual, or transgender is not a mental disorder.

OBJECTION/RESPONSE: Otto objects to this request because it is compound. Otto further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental disorder." Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Otto admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

14. Admit that being lesbian, gay, bisexual, or transgender is not a mental illness.

OBJECTION/RESPONSE: Otto objects to this request because it is compound. Otto further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "mental illness." Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Otto admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria."

15. Admit that being lesbian, gay, bisexual, or transgender is not a deficiency.

OBJECTION/RESPONSE: Otto objects to this request because it is compound. Otto further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "deficiency." Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Otto admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria." Otto also admits that many patients believe that their same-sex attractions or feelings, or their gender identity confusion, feels like a deficiency to them, for which they would like counseling. Lastly, Otto admits that people experiencing same-sex attractions or feelings, or gender identity confusion, are not "deficient" or less valuable than other persons.

16. Admit that being lesbian, gay, bisexual, or transgender is not a shortcoming.

OBJECTION/RESPONSE: Otto objects to this request because it is compound. Otto further objects to this request because it is vague and ambiguous in that it fails to identify terms like "transgender" and "shortcoming." Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto states that the practice of mental health professionals is to treat the underlying issues manifesting in psychological distress for a client. Notwithstanding, Otto admits that the Diagnostic and Statistical Manual of Mental Disorders does not list "being lesbian, gay, bisexual or transgender" as a mental condition, although it does list "gender dysphoria." Otto also admits that many patients believe that their same-sex attractions or feelings, or their gender identity confusion, feels like a shortcoming to them, for which they would like counseling. Lastly, Otto admits that people experiencing same-sex attractions or feelings, or gender identity confusion, are not less valuable than other persons.

17. Admit that, in therapy, you only affirm or encourage a minor's sexual orientation if it is heterosexual.

RESPONSE: Denied.

18. Admit that, in therapy, you do not affirm or encourage a minor's homosexual orientation.

RESPONSE: Denied. Otto states that, in therapy, he does not affirm or deny a minor's homosexual orientation. Instead, Otto listens to understand the client's perspective and addresses the underlying issues leading to the client's distress.

19. Admit that, in therapy, you do not affirm or encourage a minor's gender identity if it differs from the minor's anatomical sex.

RESPONSE: Denied. Otto states that he has not encountered this scenario with his clients.

20. Admit that "aversion therapy" techniques used in conversion therapy, such as inducing nausea, vomiting or paralysis; providing electronic shocks; or snapping a rubber band around a patient's wrist when the patient becomes aroused to same-sex erotic images or thoughts are unethical in your profession.

RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit, since no licensed mental health professional he knows has ever or would ever use such techniques as part of SOCE counseling. Notwithstanding, Otto admits that it would be unethical to perform any of the above-listed methods in SOCE counseling.

21. Admit that a minor's decision making ability is not fully developed.

RESPONSE: Admitted.

22. Admit that minor do not have the mental capacity to consistently make wise decisions about their sexuality.

RESPONSE: Otto objects to this request because it is vague and ambiguous because of its use of undefined terms such as "consistently" and "wise." Notwithstanding, Otto admits that minors need guidance, advice and counseling to make wise decisions about their sexuality, and further admits that minors should be encouraged to delay sexual activity and sexual identity labels until adulthood.

23. Admit that minors are a particularly vulnerable population.

RESPONSE: Otto objects to this request because it is vague and ambiguous because of its use of undefined terms such as "particularly," and because it does not identify any specific vulnerabilities as to which it seeks an admission. Notwithstanding, Otto admits that minors can be vulnerable when they lack the protection and support of family, but denies that minors who live in homes with stable, adult parents are necessarily vulnerable.

24. Admit that minors are influenced by their parents or legal guardians.

RESPONSE: Admitted.

25. Admit that minors are typically dependent upon their parents or legal guardians for shelter and provision.

RESPONSE: Admitted.

26. Admit that rejection can harm minors.

OBJECTION/RESPONSE: Otto objects to this request because it is vague and ambiguous, in that it fails to define "rejection" or identify any specific types of rejection as to which an admission is sought. Notwithstanding, Otto admits that some types of rejection (such as self-rejection) can be harmful to minors, while other types of rejection (such as rejection of harmful or illegal behaviors) can be beneficial to minors. Otto therefore denies that all rejection is harmful to minors.

27. Admit that, unless otherwise provided for by law, minors cannot legally consent.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Otto further objects to this request because it is vague and ambiguous, in that it does not identify the "consent" as to which an admission is sought, nor does it identify to what "law" it is referring. Notwithstanding, Otto denies that minors are always incapable of providing consent.

28. Admit that minors cannot legally consent to therapy that would seek to change their sexual orientation or gender identity.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Otto further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Otto denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

29. Admit that minors cannot legally consent to therapy that would seek to change their sexual orientation or gender identity without a consenting parent or legal guardian.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Otto further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Otto admits that, generally, before a minor can voluntarily participate in SOCE counseling, the minor's parent or legal guardian must also give their permission. Otto denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

30. Admit that a minor's parent or legal guardian must provide legal consent for any therapeutic treatment of the minor that seeks to change the minor's sexual orientation or gender identity.

OBJECTION/RESPONSE: Otto objects to this request because it calls for a legal conclusion. Otto further objects to this request because it is based on the false assumption or conclusion that SOCE counseling is or can be "done" to a person without that person's active, voluntary and willing participation. Notwithstanding, Otto admits that, generally, before a minor can voluntarily participate in SOCE counseling, the minor's parent or legal guardian must also give their permission. Otto denies that minors are always incapable of providing consent, and denies that minors are incapable of forming or participating in the formation of goals for their own therapy.

31. Admit that you have never conducted any therapy that sought to change a minor's sexual orientation or gender identity without the consent of the minor's parent or legal guardian.

RESPONSE: Otto admits that he has never conducted any SOCE counseling with a minor without the consent of both the minor and a parent or legal guardian, and without the voluntary, active and willing participation of the minor.

32. Admit that a minor's parents or legal guardian participates in setting the therapeutic goals of your treatment of the minor.

RESPONSE: Otto admits that when more than one individual participates in therapy together, each individual identifies the therapeutic goals that individual seeks in therapy. Otto further admits that parents or legal guardians approve the therapeutic goals of their minors. To the extent this request implies that a minor's parent or legal guardian can set therapeutic goals for a minor which the minor does not agree with, or that parents or legal guardians can force minors to participate in SOCE counseling against the minor's wishes, Otto denies those implications and denies that he would engage in or continue in any SOCE counseling with a minor in such context.

33. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a practice used in your profession.

RESPONSE: Otto admits that his "talk therapy" is a practice carried out solely through speech and further admits that characterizing speech as a practice in the effort to label it as conduct is a dubious constitutional enterprise.

34. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a treatment used in your profession.

RESPONSE: Otto admits that his "talk therapy" is a form of treatment carried out solely through speech and further admits that characterizing speech as treatment in the effort to label it as conduct is a dubious constitutional enterprise.

35. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a form of mental health counseling.

RESPONSE: Otto notes that he is a licensed marriage and family therapist and not a licensed mental health counselor, and that those are two different professional licenses governed by separate professional regulations. Notwithstanding, upon information and belief Otto admits that his "talk therapy" may be a form of mental health counseling carried out solely through speech, and further admits that characterizing speech as anything other than speech in the effort to label it as conduct is a dubious constitutional enterprise.

36. Admit that "talk therapy," as described in paragraphs 73, 74, and 76 of your complaint, is a mental health treatment or procedure.

RESPONSE: Otto admits that his "talk therapy" is a form of treatment carried out solely through speech and further admits that characterizing speech as treatment or procedure in the effort to label it as conduct is a dubious constitutional enterprise.

37. Admit that you wish to conduct therapeutic practices that seek to change a minor's sexual orientation.

OBJECTION/RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Otto denies that he seeks to conduct any therapeutic practice that pursues any goals other than those identified by the client, which a client willingly and actively pursues.

38. Admit that you wish to conduct therapeutic practices that seek to change a minor's gender identity.

OBJECTION/RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Otto denies that he seeks to conduct any therapeutic practice that pursues any goals other than those identified by the client, which

a client willingly and actively pursues.

39. Admit that, since the passage of the County's ordinance 2017-046, you have provided information regarding "conversion therapy," as it is defined in the County's ordinance, outside of the counselling [*sic*] or therapy setting.

OBJECTION/RESPONSE: Otto objects to this request because it is vague and ambiguous in that it fails to define what "information regarding 'conversion therapy'" means, and fails to identify with reasonable specificity the "information" as to which an admission is sought. Otto further objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. This lawsuit is about constitutionally protected speech that the ordinance prohibits, and not about constitutionally protected speech that the ordinance permits. Notwithstanding, Otto admits that he has spoken to individuals outside of counseling or therapy sessions concerning certain aspects of his practice of licensed marriage and family therapy and about the ordinance itself.

40. Admit that you have provided therapy that sought to change the patient's sexual orientation to a patient under the age of 5.

RESPONSE: Denied.

41. Admit that you have provided therapy that sought to change the patient's sexual orientation to a patient under the age of 10.

RESPONSE: Denied.

42. Admit that you have provided therapy that sought to change the patient's gender identity to a patient under the age of 5.

RESPONSE: Denied.

43. Admit that you have provided therapy that sought to change the patient's gender identity to a patient under the age of 10.

RESPONSE: Denied.

44. Admit that your religion does not require you to conduct therapeutic practices that seek to change a minor's sexual orientation.

OBJECTION/RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Otto denies that his religion does not require him to assist his patients in living according to their sincerely held religious beliefs, including in matters relating to human sexuality and sexual attractions and behaviors.

45. Admit that your religion does not require you to conduct therapeutic practices that seek to change a minor's gender identity.

OBJECTION/RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Notwithstanding, Otto denies that his religion does not require him to assist his patients in living according to their sincerely held religious beliefs, including in matters relating to human sexuality and sexual attractions and behaviors.

46. Admit that County's ordinance 2017-046 does not reference any religion.

RESPONSE: Denied.

47. Admit that County's ordinance 2017-046 does not reference any religious practice or conduct.

RESPONSE: Denied.

48. Admit that you cannot change a minor's sexual orientation.

RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Otto denies the implication that a minor's sexual orientation is rigid and unchangeable, denies that a minor's sexual orientation can never change, and denies that Otto cannot safely and effectively assist minors in understanding themselves and making the changes that the minors desire for their lives.

49. Admit that you cannot change a minor's gender identity.

RESPONSE: Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Otto denies the implication that a minor's gender identity is rigid and unchangeable, denies that a minor's gender identity can never change, and

denies that Otto cannot safely and effectively assist minors in understanding themselves and making the changes that the minors desire for their lives.

50. Admit that psychological harms may take years to manifest of be identified.

RESPONSE: Otto objects to this request because it is vague and ambiguous, in that it fails to specify the "psychological harms" as to which an admission is sought. Notwithstanding, Otto admits that some psychological harms – like the harms being inflicted by the County's Ordinance 2017-046 on the minors it deprives of the counseling and assistance they seek – make take years to be fully manifested or understood.

51. Admit that it is unethical to perform therapeutic practices that may harm a minor.

RESPONSE: Otto objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Otto admits that it is unethical to purposefully harm minors in therapy, but Otto denies the implication and premise of this request that voluntary SOCE counseling that is consistent with a minor's goals and beliefs, and that a minor seeks and willingly receives, can be harmful to that minor. Otto further denies that any study has ever found that voluntary SOCE counseling that is consistent with a minor's goals and beliefs, and that a minor seeks and willingly receives, can be harmful to that minor. Otto admits that withholding voluntary, client-directed SOCE counseling from willing minors, or forcing gay- or transgender-affirming therapy on minors who do not wish to receive or for whom such therapy conflicts with their goals, desires and beliefs, is extremely harmful and therefore unethical.

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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of August 2018, a true and correct copy of the foregoing was served on all counsel of record via electronic mail, including:

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