UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
CASE NO. 9:18-CV-80771-ROSENBERG/REINHART

ROBERT W. OTTO, PH.D., LMFT, and
JULIE H. HAMILTON, PH.D., LMFT,

Plaintiffs,

vs.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA,

Defendants.
_____/

VOLUME I

DEPOSITION OF JULIE H. HAMILTON, PH.D., LMFT

A WITNESS

TAKEN BY THE DEFENDANTS

DATE: AUGUST 30, 2018

TIME: 9:06 A.M. - 5:46 P.M.

The deposition of JULIE H. HAMILTON, PH.D., LMFT, in the above-entitled and numbered cause was taken before me Angela Connolly, Registered Professional Reporter, taken at Palm Beach County Attorney's Office, 300 N. Dixie Highway, Suite 359, West Palm Beach, Palm Beach County, Florida, on the 30th day of August, 2018, pursuant to Notice in said cause for the taking of said deposition on behalf of the Defendants.

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ALSO PRESENT:

Robert W. Otto, Ph.D., LMFT, Plaintiff

Dr. Rachel Needle

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Thereupon:

JULIE H. HAMILTON, PH.D., LMFT,

Having been first duly sworn by me, was examined and testified as follows:

THE WITNESS: I do.

MS. FAHEY: For the record, let's go ahead and do appearances.

MR. ABBOTT: My name is Dan Abbott. I'm here for the City of Boca Raton.

MS. FAHEY: Rachel Fahey on behalf of Palm Beach County. The county has with them Assistant County Attorney Kim Phan. Helene Hvizd is a senior county attorney and -- assistant county attorney, and she will be joining us in about ten minutes. The county also has with it its consultant,

Dr. Rachel Needle.

MR. MIHET: Good morning. Horatio Mihet on behalf of the Plaintiffs. With me is my colleague, Roger Gannam. Also present in the room is Plaintiff Dr. Otto; and today's deponent, Plaintiff Dr. Hamilton.

And for the record, Plaintiffs restate the same objection it had yesterday to Dr. Needle being present for these proceedings. We believe she is likely to be a fact witness in this case with respect to her interactions with the county commission and so, therefore, we think it's inappropriate for her to be here.

MS. FAHEY: And the county restates its response from yesterday.

DIRECT EXAMINATION

BY MS. FAHEY:

Q Dr. Hamilton, I will be starting with the questions for you today.

A Okay.

Q I have in front of you a binder that you may wish to refer to.

A Okay. Thank you.

Q Up here in the front of this binder is a copy of the county's ordinance. Inside this flap you will

find your answers to interrogatories.

A Okay.

Q Your supplemental answers to interrogatories and your request for admissions. So basically this is your responses to written questions.

A Okay.

Q I do not have printed out your written responses to the request for production, but the documents that you gave us for the request for production, the joint ones, are all back here --

A Okay.

Q -- if you need to refer to that. Here is a copy of the Complaint. At a certain point in the deposition I may ask you, as you observed yesterday, let's look at a specific paragraph, and so that's here for you to look at.

A Thank you.

Q So this binder here is in front of you for your reference.

MR. MIHET: And, counsel, are you giving the witness permission to consult the binder whether or not you specifically ask her to do it or is it there for when you ask her to look at it?

MS. FAHEY: I'm going to ask the witness that if you need to consult the binder, we'll take that

on a question by question basis, and I'll let you know if I'd like the answer without the consultation and if I still want the answer with the consultation because I understand that might take time to go through to find something specific and we have limited time today.

THE WITNESS: Okay.

MS. FAHEY: Thank you.

THE WITNESS: Thank you.

BY MS. FAHEY:

Q Have you ever given a deposition before?

A Yes.

Q How many times have you given a deposition before?

A Possibly three or four, maybe more. To be honest, I can remember three, but there probably were more.

Q And what type of cases have you given depositions in?

A For my clients.

Q In what context do your clients have you go and give a deposition?

A One would be -- do you want specifics?

Q I'm just generally trying to understand --

A The kind of thing maybe where they're asking

for -- a judge is asking for mental health records, so I might be called in to speak about mental health records, or where a client is confessing to sexual misconduct and I'm called in to talk about that.

Q Were any of the cases that you can recall that you gave a deposition in, did those cases involve clients -- minor clients?

A One was a deposition on an adult client, but the time that I had worked with her was a minor, so the records reflected a time period that she was a minor.

Q Okay.

A The other -- you said did they involve, so the other was sexual misconduct against a minor, but the minor was not my client, the perpetrator was.

Q Okay.

A So --

MR. MIHET: Alleged perpetrator.

THE WITNESS: Alleged, yeah.

And then I feel like there have been -- I don't remember other minors. I think they would have been marriage kinds of things in the past.

BY MS. FAHEY:

Q Okay. The one instance where you were speaking about a person who was then an adult but your records reflected treatment of a minor, did that

treatment involve the treatment of same-sex attractions --

A No.

Q -- or gender confusion?

A No.

Q Are you familiar generally with the flow of how a deposition goes?

A Somewhat, yes.

Q And you sat through Dr. Otto's deposition yesterday --

A Uh-huh.

Q -- correct?

A Correct.

Q And just so that we have it on the record, it seems like you're very familiar with the limitations of having a court reporter write down our questions. Generally what that means is you'll have to give a verbal response in the form of words because uh-huh, uh-uh does not translate well to the record, and also we will have to be cognizant of not speaking over one another because it's difficult to write down two things at once.

A Yes.

Q Okay?

A I know that will be a challenge for me, but

I'm going to try.

Q Okay. If you find that I am speaking and continuing with a question before you are finished with an answer, I'm going to invite you to let me know that your answer is not complete because I do want to know your complete answers to the questions today.

A Okay.

Q As you heard doctor -- Mr. Abbott. I say doctor a lot so I got confused -- Mr. Abbott yesterday say that he was not a licensed marriage family therapist and so he confessed that some of the language might not translate well from me to you.

If I ask a question in a way that is misusing your terms of art for therapy, if I'm saying "therapy" and I should be saying "counseling" or vice versa, will you please allow me to correct that? Will you please let me know that the question doesn't make sense?

A Yes.

Q And if I ask you a question that you don't understand at all, will you please let me know?

A Yes.

Q Okay. At any time if you need me to restate a question or rephrase it, will you please let me know?

A Yes.

Q All right. So I'm going to direct you to this

document that you have in the front of your binder. It is Bates labeled PBC 001 through PBC 0014. It's a copy of the ordinance. And when I say "the ordinance," I'm going to be referring to Palm Beach County's ordinance. I represent Palm Beach County.

A Okay.

Q Mr. Abbott, when he speaks to you later, most likely will be referring to the city's ordinance, but I'll let him let you know what he refers to, but I'm going to be referring to Palm Beach County's ordinance.

A Okay.

MR. MIHET: Are we marking this as an exhibit?

MS. FAHEY: No.

MR. MIHET: No.

BY MS. FAHEY:

Q I just want to point you to this ordinance, and I want to refer you to -- at the bottom you see the tiny little numbers, PBC00 something? Will you turn to PBC0012.

Okay. The top of that page, line 1, there's a definition for conversion therapy. When I refer to "conversion therapy" today, I'm going to be referring to this definition, okay? If for some reason you need to clarify and you're not referring to that or my question doesn't make sense in the context of that, I'm going to

ask you to let me know, but if I say "conversion therapy," that's what I'm going to be referring to, okay?

MR. MIHET: I'm going to object as to form.

MS. FAHEY: What's wrong with the form?

MR. MIHET: It assumes that the definition of conversion therapy in the ordinance is clear, not vague, not ambiguous, and understandable by a reasonable person --

MS. FAHEY: Okay.

MR. MIHET: -- which is a legal issue in the case that the parties are going to be debating before the court.

MS. FAHEY: Okay. I understand.

So I'd like to mark for this deposition Palm Beach County's Exhibit 1.

MR. MIHET: Can I recommend that we maintain the same numbers from yesterday because we had Defendants' -- we had a number of Palm Beach County's Exhibits, you know, 2, 3, 4, 5 and 6, and now we're going to have them again here. It may get confusing. It would be easier to just continue with the numbering scheme that we started yesterday.

MS. FAHEY: So I thought those were depo

exhibits to Dr. Otto. These are exhibits to Dr. Hamilton.

MR. MIHET: Okay. I think it would be clearer if we just have a running number of exhibits. That's how we typically do it.

If you prefer to do it this way, I think it's going to be confusing when you say it's Exhibit 7 but not to Dr. Otto, to Dr. Hamilton.

MS. FAHEY: Okay. If that's what you prefer, we just won't have Exhibit 1 to her deposition. So what number --

MR. MIHET: No, it would be Exhibit 7. I think we left off with Exhibit 6, if I'm not mistaken, yesterday.

MS. FAHEY: Let's do it that way.

MR. MIHET: Okay.

MS. FAHEY: Okay. So this will be Exhibit 7.

(Thereupon, Defendants' Exhibit 7 was marked for identification.)

BY MS. FAHEY:

Q Dr. Hamilton, do you recognize Exhibit 7?

A Yes.

Q For the record, Exhibit 7 is Hamilton 001 and Hamilton 002 and Hamilton 003. It's a three page document.

Is this your resume, Dr. Hamilton?

A Yes. My curriculum vitae.

Q Your curriculum vitae?

A CV.

Q I see that it says that it's an abbreviated CV. Do you have a non-abbreviated one?

A No. Not to my knowledge I will say. I don't think I do.

Q When was this resume last revised?

MR. MIHET: Objection. The witness said it's a CV.

BY MS. FAHEY:

Q CV, sorry.

A To be honest, I don't remember if I made any changes before submitting it or not. Sometimes when I pull it up when someone asks for it there are new updates to put on it so I will update it, but I don't think I updated this one, but I honestly don't know.

Q Do you know whether this CV is up-to-date?

A It looks like it is up-to-date.

Q Where did you learn the talk therapy practices that you use?

A In my master's program at Nova Southeastern University.

Q What about the doctorate program, the Ph.D

program?

A I'm sorry, when did I first learn them? Did you say when did I first learn them?

Q I did not.

A Oh, I'm sorry.

Q That's okay.

A What was your question, the first question?

Q Did your doctor of philosophy in marriage and family therapy inform your practices --

A Yes.

Q -- that you do now?

Okay. Did you learn at Nova Southeastern University, in either your master's program or your doctorate program, practices to specifically address unwanted same-sex attractions?

A I did not learn practices to specifically address any issue. It was how to work with people in general.

Q Did either your master's program or your doctorate program cover the topic of same-sex attractions?

A I believe, yes.

Q And which one would it have been?

A I believe I took human sexuality in my master's program.

Q Any other coursework that you can recall that addressed same-sex attractions?

A I don't recall that specific topic other than in general human -- family dynamics and human relationships.

Q And would that have been in a specific master's course or doctorate course?

A The family dynamics and human relationships? That was throughout both programs, master's and doctorate.

Q And what about questions about gender identity and gender confusion, did you have any coursework in either your master's program or your doctorate program that specifically addressed that topic?

A Probably human sexuality in my master's program.

Q And how about your bachelor of science coursework in philosophy at Tennessee Temple University, did any of your coursework in your undergraduate degree cover sexual orientation or gender identity?

A I honestly do not remember. I do want to state that in every university that I attended, a theme was human relationships and how people do relate to one another in various ways and that was the real thrust of a marriage -- because marriage and family therapy is

about personal dynamics.

Q So I'm going to be looking at Hamilton 002, the second page of your CV. Have you spoken publicly -- I see you have a section about presentations.

A Uh-huh.

Q Have you spoken publicly since December of 2017?

A Since December of 2017? Yes. No. December of 2017? We're in 2018. Have I spoken publicly? Yes.

Q Okay. Where have you spoken?

A I spoke at my church.

Q Where is your church?

A West Palm Beach.

Q Which church do you go to?

A Truth Point.

Q Is that the only time you have spoken publicly since December of 2017?

A Honestly, I don't -- I can't say for sure that's the only time I may have spoken.

Q When you spoke at the Truth Point Church in West Palm Beach, were you speaking to a live audience?

A Yes.

Q And what was the topic that you were speaking on?

A Love and relationships. It was a Valentine

thing.

Q To your knowledge, is that talk available online?

A Might be. It probably was recorded on their website I would guess. I don't know for sure.

Q During that talk do you recall whether you addressed same-sex attractions in minors or gender identity confusion in minors?

A I don't think I ever addressed sexual attractions or gender identity at all. I don't think -- definitely not. I can't imagine how that would have fit in with the talk. With minors, no.

Q Okay.

A Yeah, definitely wasn't the point of the talk.

Q Since December 2017 have you spoken privately -- and I mean to family or friends -- about sexual orientation or gender identity?

A Have I spoken --

MR. MIHET: Form.

THE WITNESS: -- privately? I do want to back up. As far as speaking since then, I said I don't remember. It is -- when you mentioned live, there may have been a radio thing, but I honestly don't know if it was '18 or '17 when that happened, so I really -- yeah. So, anyway, it's possible that I

spoke about other topics since then.

And your next question was have I --

BY MS. FAHEY:

Q Spoken privately.

A Privately. Have I spoken --

MR. MIHET: Form.

THE WITNESS: -- privately about gender identity or -- yes.

BY MS. FAHEY:

Q Okay. Will you please share with me when and in what context?

A I speak about it all the time because I'm so appalled that the county has taken away our freedom of speech in the therapy office. So I talk about it with my friends, my family. Yes, I talk about it a lot on a personal -- are you talking about just the issue in general or trying to help people change?

Q I'm talking about have you spoken on the subject of sexual orientation --

A Yes.

Q -- or gender identity?

A Sorry.

Q That's okay. In a regular conversation it would be normal for you to say your answer before I was finished, so I'll say it clearly.

Since December 2017 have you spoken privately with family or friends on the subject of sexual orientation or gender identity?

A Yes.

MR. MIHET: Asked and answered.

BY MS. FAHEY:

Q Okay. We were just getting the whole question and the answer out.

A So, yes.

Q Okay. And you explained to me that that was in the context of speaking with your friends and family specifically about the bans that we're in this lawsuit about today?

A So what was I speaking about? The bans for sure, the fact that speech has been taken away. I talk about, with friends and family, about the dangerous thing that's happening in our culture where gender identity confusion is being increased in young children because of how they're being taught, that they have lots of options of what sex they can be.

Yeah, I'm very distressed about what's happening in our culture and how there are more confused children. More and more children are becoming confused and we have less ability to help them, so I talk about it a lot.

Q Did you feel constrained by the Palm Beach County's ordinance in speaking to your friends and family about the issues that you just shared with me that you spoke about?

A I did not feel constrained about speaking about those issues, but if I were to try to help someone who was asking me about their gender confusion, I would definitely feel constrained, even if it was my own child because the ordinance says paid or unpaid.

Q Do you have any minor children?

A Yes.

Q What are the ages of your children?

A Six and eight.

Q And are either of your children seeking therapy that would seek to change their sexual orientation or gender identity?

MR. MIHET: Objection.

THE WITNESS: They are not; however, if they ever became confused because of a book they picked up at the library or because of something that they heard taught to them and they had confusion about it, I do not believe that I would be at liberty in America to help them clear up their confusion based on this ordinance.

BY MS. FAHEY:

Q I understand you have the potential concern. Do you have a present concern that either of your children have gender confusion or sexual orientation questions?

MR. MIHET: Asked and answered.

THE WITNESS: No.

BY MS. FAHEY:

Q Okay. Now I see that you taught at --

A Can I also add another answer to that? When you were asking if I had felt constrained to talk to family and friends, if I were giving a talk on any number of things and someone -- if I was speaking in a church and someone went and got their child out of childcare and brought them to me and said, "Hey, could you speak with my child about -- you know, they're confused and could you speak to them?" I would have to tell them, "No, I'm actually not allowed to speak on that. Even though I'm not in my counseling office, even though you're not paying me, I'm not allowed to help you with that because I can't talk to your child."

So there are a number of contexts. I could go on and on with all the different contexts outside of the therapy office that I have felt constrained and could potentially feel constrained in the future.

Q Okay. You used to teach classes at Palm Beach

Atlantic University, correct?

A Yes.

Q Did you teach human sexuality theory and techniques at Palm Beach Atlantic University?

A No.

Q What classes did you teach?

A Marriage theories, family theories, foundations of counseling, dynamics in marriage and family, legal and ethical issues, group counseling. I don't remember if there were others.

Q Did you teach any classes specifically on the topic of sexual orientation or gender identity?

A That was covered in some of those classes.

Q And when --

A I cannot remember.

Q I'm sorry.

A Go ahead.

Q When you say "covered in," was that something that you spent more than a week discussing with the students?

MR. MIHET: Form.

THE WITNESS: I don't think so. I'm not sure. I don't think so.

BY MS. FAHEY:

Q And are there any books that you recommended

to your students as recommended or required reading that covered sexual orientation or gender identity?

A I don't remember any books that specifically covered that, but whether that was addressed within books that were recommended or required, I don't know.

Q Do you still have the syllabi of the classes that you used to teach?

A They would be on record at Palm Beach Atlantic.

Q Do you know whether you have a copy?

A I know that my computer crashed long after -- or not long after I was there, but I feel like I recently -- in looking for documents, I feel like I recently came across some things that were saved on a flash drive, so I think that there could be some available.

Q Okay. At PBA did you teach on the causes of homosexuality?

A Probably on theories of contributing factors within some of the classes that I taught.

Q Did you teach at PBA on how to reduce or eliminate same-sex attractions?

A I don't know. And some of what you're -- what you're asking, I'm thinking in terms of lecture material not necessarily all outlined in writing, so I'm trying

to recall every -- sometimes in a -- as a lecturer you include a number of topics and the classes were four hours, so it's very possible I talked about topics that I wouldn't have record of ever talking about, you know what I mean? I didn't use PowerPoints in any of my classes so, yeah, I have -- I cannot recall.

Q Why did you stop teaching at PBA?

A I had a baby. I wanted to spend time with the child, my baby.

Q Do you have plans to go back to teaching?

A No, I don't really have any plans.

Q Okay. I am going to be handing you what we will be marking as Defendants' Exhibit 8. This is Hamilton 004.

MR. MIHET: Why don't we have you testify from the one that's officially marked.

THE WITNESS: Oh, thank you.

(Thereupon, Defendants' Exhibit 8 was marked for identification.)

BY MS. FAHEY:

Q Do you recognize Defendants' Exhibit 8?

A Yes.

Q What is Defendants' Exhibit 8?

A My license as a marriage and family therapist.

Q Is this a true and correct copy of your

license as a licensed marriage and family therapist?

A Yes.

MR. MIHET: Form.

BY MS. FAHEY:

Q Now the address that appears here on your license, what address is that?

A My office address.

Q How long have you been at that office?

A I would say probably ten years, 2008.

Q Is the address correct?

A Yes.

Q What do you do to maintain your license?

A I take 30 hours of continuing education credit every two years and go through the procedure then of reporting that I have done that and renewing the license.

Q Is there any specific subtopics that you have to hit with those 30 credits? For example, in the legal field we have to hit a certain number of, like, ethics credits.

A Uh-huh.

Q Is there an equivalent for the licensed marriage family therapist continuing education?

A There are, but it changes each biennium. So sometimes it's legal issues. It used to be HIV and

AIDS. It used to be domestic violence, but it changes so I'm not sure what we'll be required for 2019 renewal.

Q Do you know whether they offer -- is it called CEU or CEC?

A CEUs.

Q Okay. Do you know whether they offer CEUs specifically in sexual orientation or gender identity?

A In changing sexual orientation or gender identity or --

Q Just specifically on the topic --

A Probably.

Q -- of sexual orientation or gender identity.

A I would guess that they do, but I'm not sure.

Q Have you taken any CEUs specifically in sexual orientation or gender identity?

A I don't know. I've been licensed for 18 years, I'm not sure. I can't remember all the CEUs I've taken.

Q How about in the last renewal period, have you taken -- do you recall whether you took any CEUs in the last renewal period, last two years or so, specifically on sexual orientation or gender identity?

A I'm so sorry, I don't even remember what they were.

MR. MIHET: Don't feel bad. I don't remember

the ones I take either.

THE WITNESS: Oh, good. Thank you.

BY MS. FAHEY:

Q Do you remember any of the CEUs that you've taken in the last two years or so?

A Oh, I honestly don't know if it was the last biennium or the one before that, but I did some on suicide, depression. I think I may have done one on aging. Technology and its effects on minors, I did that one. I can't recall any others off the top of my head right now. I might be able to think of them if I give more thought to it.

Q If you remember later, let me know.

A Okay.

Q Do you know if you've had to take any CEUs in ethics?

A This last biennium I do think there may have been a legal course now that you're saying that, but I'm not 100 percent sure. Yeah, I believe there might have been. I can't remember if it was a required one or not.

Q Okay.

A Okay.

Q What is your -- so I'd like to talk about ethics a little bit.

A Uh-huh.

Q What's your understanding of your ethical requirements as they relate to boundaries?

A To boundaries? Well, we are to avoid dual relationships, so we are to not have clients that we have another relationship with at the same time.

Boundaries would also include -- so that would mean, you know, with your client you can't establish a friendship or a romantic relationship either. I don't have the ethical codes in front of me to quote what boundaries say in the ethical codes, but what I think of is not disclosing -- not making the session about yourself. So a lack of boundaries would be making this -- you know, talking about your own problems to your clients and that kind of thing. Or hiring clients for services later, that kind of thing.

Again, I don't -- I don't have the exact wording of what's stated in the ethical codes, but to maintain professionalism and have a respectful relationship, yeah.

Q And that ethical requirement as it relates to boundaries, does that preclude you from treating family members and friends as clients?

A In the therapy office, yes. I could not have them come into the therapy office as my client.

Q What is your understanding of ethical

requirements as they relate to self-disclosure?

A I believe it's that you are self-disclosing for the purpose of helping a client but not self-disclosing for the purpose of benefiting yourself. So not self-disclosing to make myself feel better for them to give me advice or comfort me or in any way meet my needs, but self-disclosing for the purpose of meeting their need. As well as I would say there are times where a conflict of interest may arise and you self-disclose perhaps your beliefs or your opinions if those would interfere with you being able to help the client achieve their goals. That would be appropriate self-disclosure.

Q Now I understand that you can't treat family or friends in the office. Have you helped family or friends like you've -- like you said in -- like not in the office --

A Right.

Q -- in the past?

A Right.

MR. MIHET: Form.

THE WITNESS: What's interesting is that in our field, because what we do for a living is we talk to people about their problems, I would never say that I have formally provided therapy for any

of my family or friends; but by being a family member or a friend to someone, there are many, many times where I do talk to people about their problems. And my guess is that my therapy training and skills in how to communicate and how to listen, how to empathize, probably come into play, so I'm using probably therapeutic skills.

Even though I'm not intentionally trying to be a therapist, I might be trying to be a mom or a friend or a daughter or a sister or a wife, but you can't really -- putting on a therapy hat and taking off a therapy hat is not like being a dentist and putting a filling in a tooth. It's just human interactions, so those interactions do take place outside the therapy office even though certainly my family and friends wouldn't say -- or I wouldn't say I'm doing therapy. They might say -- I do have friends that sometimes say, "Oh, thanks I owe you" jokingly because it feels like they've talked to a therapist because they've talked to someone with training in how to listen.

BY MS. FAHEY:

Q Now I was asking questions about your understanding of your ethical requirements, and you said "I don't have the ethics in front of me." Which ethical

codes were you thinking of when you said I would -- I don't know what the exact wording is. Which one were you thinking of?

A The marriage and family -- the American Association of Marriage and Family Therapists.

Q So is that the AAMFT?

A Yes.

Q I am going to point you to a document that was produced in the joint production. It is PL Joint 001, and this is the American Association of Christian Counselors, AACC, Code of Ethics. Is this a code of ethics that you follow?

A No. Not that I wouldn't. I don't -- I'm not a member of the American Association of Christian Counselors.

Q Are you --

A And I might agree with a lot that's in there. I don't know.

Q Okay. Do they have the authority to discipline you, the AACC?

A No.

Q So is it mandatory for you to follow the code of ethics of the AACC?

A No. I will say that the way it works is that I have a code of ethics for my profession under which

I'm licensed -- the field that I'm licensed in, and I have the statute, the Florida Statute, but I definitely also don't have a code of ethics issued to me by the county or the city either, and that's one of the biggest problems with this ordinance is that --

MR. MIHET: We'll get there.

THE WITNESS: Okay.

MR. MIHET: She didn't ask you about that yet.

THE WITNESS: Sorry. Yes. Okay.

BY MS. FAHEY:

Q So I understand you follow the AMFT --

A Yes.

Q -- as your code of ethics.

A Yes.

Q Are there any other code of ethics that you follow as binding you?

A No.

Q Does the AMFT have the authority to discipline you?

A I believe if you're a member they have the authority to suspend your membership or take away your membership, but I believe it would be the state that would have the authority to take away my license.

Q I'm going to borrow this real quick.

Now you mentioned that the AACC code of ethics

was something that you did agree with some of the --

A Perhaps I would. I don't know for sure.

Q And I want to ask you whether or not you do agree with a specific provision.

A Okay.

Q I have turned to PL Joint 026. It is on page 26 of the document, and I'd like to direct your attention to provision 1-530-a. It's "Not Imposing Values." If you could read that and let me know when you're finished reading.

A Yes. "While Christian counselors may expose clients and/or the community at large to their faith orientation, they do not impose their religious beliefs or practices on clients."

Q Do you agree with that --

A Yes.

Q Okay.

MR. MIHET: Let her finish.

THE WITNESS: Sorry.

MS. FAHEY: I think we got that.

BY MS. FAHEY:

Q Okay. I'm going to move back to the location of your practice. You've let me know that the address that's on your license is the correct address for your practice?

A Uh-huh.

Q Do you engage in therapeutic practices in any location other than your office?

MR. MIHET: Form.

THE WITNESS: I also provide telephone therapy.

BY MS. FAHEY:

Q Where are you when you provide telephone therapy?

A I have been in my offices and sometimes at home.

Q What city is your home in?

A West Palm Beach.

Q Are there any other locations where you provide therapy?

MR. MIHET: Form.

THE WITNESS: No.

BY MS. FAHEY:

Q And so I'm just going to run through some possible locations --

A Okay.

Q -- and if you could let me know yes or no. Boynton Beach?

A No.

MR. MIHET: Counselor, are you asking where

she is present or where her clients are present?

MS. FAHEY: Where she is present when she provides therapy.

THE WITNESS: At this time in my life. So not that I won't ever be in those locations in the future because I have a very limited practice since my children are small, but I may go back to having two locations as I once did. Okay.

BY MS. FAHEY:

Q Where was your other location?

A Boca Raton.

Q What was the address of your other location?

A For a while I practiced at Spanish River which was, I believe, 2400 Yamato Road, I'm not positive, and then I had two other offices in Boca. I do not remember the addresses off the top of my head. One was on Glades Road in, like, Twin Towers near the Town Center Mall, I believe. I think the other one might have been on Federal Highway.

Q Do you know one way or another whether those two other locations were in the city limits of Boca Raton or if whether it was unincorporated Palm Beach County?

A I believe I had an occupational license in Boca, so I believe that would have been the city is my

guess. I don't remember. It was prior to '05.

Q You presently have one office location --

A Right.

Q -- correct? Do you have any current plans to open a new office location?

A I do not have any plans beyond today about my profession, private practice.

Q Okay. So I'm going to get back to the locations and check to see whether you are currently --

A Currently.

Q -- providing therapy in that location, and I am referring to where are you when you provide therapy.

A Okay.

Q Lake Worth?

A No.

Q Greenacres?

A No.

Q Delray Beach?

A No.

Q Riviera Beach?

A No.

Q Wellington?

A No.

Q Boca Raton?

A Not currently.

Q How about anywhere outside of Palm Beach County?

A No.

Q Broward County?

A No.

Q And I understand that you have clients that you speak to on the telephone. Can you give me an idea of generally the scope of where those clients are?

A Okay. Boca Raton, Orlando, Tampa, and I have one that's out of state, which is Kentucky.

And the way it works when we practice out of state is I check with the state to make sure they have no prohibition against an out-of-state licensed provider providing telephone therapy, so Kentucky is one that's fine. I think I provided in Georgia. None of these are minors. And there have been other states, such as New Mexico where I had to say no because they have laws that prohibit an out-of-state therapist from providing therapy in that state, and Hawaii as well. I actually don't remember what happened with Hawaii, if that was permissible or not permissible.

Q Is the client that you were referring to that you said is located in Boca Raton and you provide telephonic therapy to, is that client a minor?

A No.

Q Do you have any minor clients that reside in Boca Raton?

A I don't know. I don't think so. I don't know.

Q What's the name of your practice?

A It's just under my name as an individual provider: Julie, I think, Harren Hamilton.

Q Does your practice have a -- is it incorporated? Is there a partnership?

A No, just an individual. I think it's called an individual proprietor -- what is it? Proprietaryship or whatever. I don't remember the word.

Q And you were -- you said something that when you were previously in Boca you had a license through Boca. What was that?

A Well, we have an occupational license when we're in private practice, so I have one from the county and one from the city that I'm practicing in.

Q Okay. So do you have an occupational license from Palm Beach County?

A Yes.

Q And do you have an occupational license for the City of West Palm Beach?

A Palm Beach Gardens is where I practice.

Q Palm Beach Gardens. Do you have one for the

City of West Palm Beach?

A No, not currently. I used to practice in West Palm. I used to have an office in West Palm.

Q Do you have a business card that you give people?

A I do.

Q If your attorney does not object, would you mind showing it to him to see if we can make a copy of that today?

A Sure, if I have one.

MR. MIHET: Sure.

MS. FAHEY: Thank you. So we'll make a copy of this and mark this -- are we on 9?

MR. MIHET: 9.

(Thereupon, Defendants' Exhibit 9 was marked for identification.)

BY MS. FAHEY:

Q How long has this been the design of your business card?

A I just reordered them in probably January, and I don't know if I changed the design or not. I don't think so.

Q Has there ever been a time that you can recall that your business card advertised that you addressed same-sex attractions in minors?

A Not on my business card.
Q Has there ever been a time that you recall that your business card advertised that you address gender confusion in minors?
A Not on my business card.
Q I understand that it's a sole proprietorship.
A Thank you.
Q And I assume that you own your business; is that correct?
A Yes.
Q Does anyone else have an ownership interest in your business?
A No.
Q Do you have any employees?
A No.
Q Does your business work with any other therapists that would say that they practice under this business?
A No.
Q Do you have a salary?
A No.
Q Is your compensation structured based upon how many clients and how many sessions you have?
A Yes.
Q Are your clients paying out-of-pocket or do

you accept insurance?

A Are they paying out-of-pocket? They all pay me out-of-pocket. Some clients will -- I will give them a form that they can deal with their insurance companies if they want reimbursement if it's something that's covered. I do not work with any insurance companies to bill. With one exception, I think there is an EAP that I did agree to, for the client's sake, to go ahead and bill the EAP, which is I don't think an insurance company. It's something with their place of employment.

Q Was that client an adult?

A Yes.

Q How do you market your services?

A Word of mouth. I also get referrals because of people hear about either a talk that I've done or maybe on the radio or something like that, so it's not me personally marketing my services only but them hearing something that I've said or done and then them contacting me so...

Q Have you in the past advertised on the radio?

A I have not -- oh, yes, I did advertise once. Years ago, yes.

Q And what radio outlet or station did you advertise on?

A WAY-FM.

Q And that was years ago?
A Uh-huh. 2002, I believe. I'm not positive.
Q Do you have any plans to do a new radio ad?
A Not a new ad, but there's informal advertising when you speak on the radio so...
Q Have you ever advertised through the newspaper?
A Maybe -- I think -- I think Rob mentioned the Good News Newspaper. When I was with Spanish River, I believe they did. That would be it.
Q Okay. So you have not advertised Julie Harren Hamilton, Ph.D, LMFT, in the newspaper?
A Right, I have not. Not my private practice.
Q And how about your private practice, have you advertised that through any other print media such as flyers or posters?
A My private practice? No.
Q You have a website, correct?
A Yes.
Q Okay. Is your website something that you consider advertisement?
A Yes, I suppose so.
MS. FAHEY: I will mark this as 10. Thank you.
(Thereupon, Defendants' Exhibit 10 was marked

for identification.)

BY MS. FAHEY:

Q Do you have Exhibit 10 in front of you?

A Yes.

Q Okay. Do you see at the bottom it says http://drjuliehamilton.com/therapy?

A Yes.

Q Is that your website?

A Yes.

Q Does this document, Defendants' Exhibit 10, appear to be a page from your website?

A Yes.

Q Do you know, is this page something that you created?

A I believe I had a web designer do this.

Q Did you create the content of the website, of this web page?

A Probably, yes.

Q Do you advertise that you address same-sex attractions or gender confusion in either minors or adults on this page?

A I don't believe I do on this page.

Q Was there a time in the past where you did advertise that you addressed same-sex attractions or gender identity issues on your website?

A I don't know for sure. I think various forms -- I think I'm advertising that I help with various forms of difficulty.

Q Okay. Do you recall having changed your website content because of the county's ordinance or the Boca Raton ordinance?

A I think that in the past I never advertised specifically for gender identity confusion or sexual orientation confusion because I did not see it as a separate issue. I deal with a wide variety of issues. However, in the present and in the future, I most definitely want to make myself more available to families of children that are struggling with gender identity confusion because it's a problem that's increasing and a very, as I said earlier today, very distressing problem.

I'm very concerned about children that go without help for this issue when they're young, so I do want to start advertising to help those gender confused young children and their families, and I'm not able to do that because of this ordinance.

Q Is this the page of your website where you would do that?

A No.

Q The therapy page?

A I would put my name -- no, sorry. I would -- I would put my name on a referral list of organizations that regularly get calls from distressed parents looking for help. I would put my name on as a provider for them because it is possible to help these confused children move beyond their confusion, but the ordinance restricts me from making my services available.

And one last thing. The ordinance instead suggests that the best treatment for these children is to help them become the opposite sex.

Q Do I understand you correctly to say that -- imagine there's no ordinance in Palm Beach County --

A Uh-huh.

Q -- or Boca Raton -- that you would not amend your website in any way with respect to there being no ordinance, is that true?

MR. MIHET: Form.

THE WITNESS: I'm not sure. To be honest, I'm not sure what I would do. I haven't thought ahead with that. I have one specific place in mind that I would like to make myself available and known that I'm not able to do because of the ordinance.

BY MS. FAHEY:

Q What is that referral list that you're referring to?

A There's an organization called Focus on the Family, and they get a lot of calls from parents that are not knowing what to do with their little girls that think they are boys or their little boys that think they are girls.

Q And is that referral list -- if you could help me understand, is that something that anybody could go look at the referral list online and see a bunch of names?

A I'm not sure to be honest.

Q Have you ever attempted to be on that list in the past?

A I don't -- I don't know if I was -- I don't know if I was actually -- I feel like I may have been on it at some point, but I don't know.

Q Did you ever --

A But I want to -- so I -- I feel like people have called me and said they heard of me through that organization, but I don't think I'm on the provider list, so I would like to make it more clear with that organization that I am a provider. Maybe there are some people that are giving out my name in that organization, but I want it to be better known throughout the organization so that more families will know that there's help available in Palm Beach County.

Q In the past have you ever provided your name as a provider to Focus on the Family for their referral list?

A I don't think them. I think another one maybe. No.

Q What is --

A I'm not sure.

Q -- the referral list that you recall providing your name to as to be put on to a referral list as a provider?

A There is probably a provider list within Exodus.

Q When you say "Exodus," are you referring to Exodus International, Exodus Ministries? What -- is it just Exodus?

A It may have been Exodus International maybe or North America, I'm not sure.

Q Does that organization still exist?

A No. It was replaced by two other organizations.

Q What are the names of the two organizations?

A Restored Hope Network and Hope for Healing.

Q Can you say that first one again?

A Restored Hope Network and Hope for Healing.

Q Are you on a referral list for either Restored

hope Network or --

A I don't think so.

Q Sorry. I blanked on the second one.

A Sorry.

Q So how about that second organization, are you on a referral list for them?

A Not that I know of.

Q Have we covered the world of advertisement that you have, in the past, engaged in for your private practice?

A I guess the only one we haven't covered is public speaking, that when I public -- when I do public speaking parents often come up to me afterwards and they're distressed about their children. And now if they come up to me, I have to say, "I'm sorry, I'm not allowed to help you" according to the county commissioners.

Q When you do the public speaking, do you, in those public speeches, say "If anyone wants to retain me as a therapist, I'm accepting new clients. Come talk to me afterward"?

A I do not, but they generally recognize an expertise and would like to solicit the help, so I wait for them to solicit, and they often do, and now I would have to turn them down.

One other thing I would say is that I do sometimes say that if someone is distressed about this issue, I would recommend therapy for them. I don't say "Come see me personally," but I say, "I would recommend therapy." I'm not able to say that now for if they're a minor. I can't say here are -- "If you're confused, if you're feeling suicidal or depressed, here are some things you can do. You can contact a therapist." I can't say that anymore because they're not allowed to contact a therapist in Palm Beach County.

Q So is it your position that you are constrained from recommending SOCE therapy, sexual orientation change efforts therapy?

A I am constrained from recommending therapy to minors in this county, yes.

MR. MIHET: Rachel, we've been at it for an hour. I could use a short break whenever you deem it appropriate.

MS. FAHEY: Okay. Well, we have no question pending. How about now?

MR. MIHET: Okay.

(Thereupon, a short break was taken from 10:01 a.m. to 10:10 a.m.)

BY MS. FAHEY:

Q All right. We're back on the record,

Dr. Hamilton. I'd like to ask you questions about diagnosing. As a licensed marriage and family therapist are you authorized to give a diagnosis?

A I believe that we can.

Q Do you give diagnoses?

A I do not diagnose for my own clinical purposes; however, if they are using insurance, they have to have something that's diagnosable. So if they have a diagnosable condition, I put a diagnosis on the form that I give them to send to their insurance company.

Q What are the types of diagnoses that you have, in your practice, given a patient? The ones that you were just mentioning who needed to have a diagnoses for insurance purposes.

A Common issues that people bring in to my office are anxiety, depression, adjustment disorders of various types. Probably those -- those are the only ones I can think of.

Q I understand from your answer to interrogatory number 22 that in the past nine years you have had 11 patients that have had either gender identity confusion or same-sex attractions that were unwanted by them and that -- so you've had 11. Of those 11, do you recall whether any of those were situations where there was

insurance and so a diagnosis was needed?

A Gosh, I don't remember.

Q Would it assist you to look at the list of the Doe 1 through 11?

A To be honest, no. I would have to see their files.

Q Have you in the past given a diagnosis that you can recall to a person who had unwanted same-sex attractions, either a minor or an adult?

A So let me say this: If they are coming in and that is their presenting problem, that's not diagnosable and insurance is not going to cover that. So if they ever did ask me to use insurance for that issue, I would have to say "That is not considered a mental health diagnosis. You cannot use your insurance for this."

Q Is that answer still true if I were to supplement unwanted same-sex attractions with gender identity confusion? Is gender identity confusion where you would give a diagnosis?

A In the past it used to be called gender identity disorder, so if a child had -- I don't ever recall diagnosing a child with that. I don't recall using insurance to work with that issue. Now it would be called gender dysphoria if they were having stress over their gender confusion, but I don't recall giving a

diagnosis of that for clients.

So the answer to the question about have I ever, it would have only been if they came in reporting something that was diagnosable and then the same-sex attraction came up as a secondary issue or an equally problematic issue for the client. Does that make sense?

Q Yes.

A So if they came in, their parent brought them in saying they were depressed so then maybe they had a diagnosis that had to do with what they came in for and then we find out that they are also dealing with same-sex attractions, but I do not recall doing that.

Q And you also don't recall ever diagnosing a client with gender dysphoria, is that true?

A Right.

Q Do you recall ever diagnosing a client with gender identity disorder?

A Is the old term. I don't -- again, the only reason I would have used a diagnosis is for insurance purposes. I do not recall that ever being used for insurance purposes.

Q The diagnoses that we are talking about, gender dysphoria which used to be GID, and the fact that there isn't a diagnosis for unwanted same-sex attractions, is the -- DSM, is that the -- is that the

authority from which you pull "This is a diagnosis, this is not a diagnosis"?

A That is the authority for the insurance companies, but it is not the authority for my clinical practice because I'm trained as a marriage and family therapist, so we don't think in terms of diagnoses.

Q Okay. And are there any authorities that set out a list and definitions of diagnoses other than the DSM that you use?

A Not that I know of.

Q As a licensed marriage and family therapist are you authorized to create treatment plans?

A I'm sure I could.

Q Do you?

A No.

Q Are you authorized to treat patients?

A Yes.

Q Do you?

A If by "treat" you mean do I talk to them in therapy and help them with their problems, I do.

Q So now I'd like to talk to you about typical therapy, what it involves. There's a portion of my questions of you where I'd like to get specifically into the Does that you've identified, 1 through 11. This is not necessarily that time. Now I just want to

understand your practice and therapy as is conducted in your private practice.

What does the intake process look like for your practice?

A It would start with an initial phone call from someone asking for help. Sometimes that phone call just involves setting up an appointment if they know that's what they want to do. Sometimes that would involve them talking about their problem because they want to talk about it and find out if I'm the right therapist for them. That's the first step is the phone call.

The second step would be coming into the office. And the intake would be I give them paperwork to read and sign. And -- go ahead.

Q I was going to ask you on the topic of paperwork, I have with me what we -- this is Exhibit 11. This is Hamilton 005 and Hamilton 006, Exhibit 11. Do you have Exhibit 11 in front of you?

A Yes.

(Thereupon, Defendants' Exhibit 11 was marked for identification.)

BY MS. FAHEY:

Q You just referred to that they would be given paperwork. Is Exhibit 11 the paperwork you were referring to just now?

A This plus the intake form.

Q Okay. What is contained on the intake form?

A I thought you had a copy of it. It's their name and address and a date of birth, date of intake, phone number, who lives in their household, any previous treatment, that kind of thing. No, they don't sign it. It's general information about them.

Q Okay. Does this intake form include a section where they, hypothetically at a doctor's office, you might check off "I'm experiencing bleeding or headaches" or something like that? Does it include the equivalent for a therapeutic practice?

A No. No checklist of symptoms, just one line, "What is the reason that you're here today?" to fill in the blank, so short answer.

Q Okay. So there's a phone call, they make an appointment, may or may not have a substantive conversation, then they come in, they fill out what we have marked as Defendants' Exhibit 11, which is a "Consent-to-Treat and Financial Agreement," and they also fill out an intake form?

A Yes.

Q Is that the intake process?

A Yes. Unless -- well, I mean -- so I don't call it a formal intake, it's just the first session,

but in that session I also go over this verbally with them.

Q And when you said "this," were you referring to Defendants' Exhibit 11?

A Yes.

Q Okay. We may refer later more to the consent form but for now I'm going to keep going.

Do you have a typical length of the therapy that you provide, such as 12 weeks? Is that true for your practice?

A No. It really ranges, a wide range.

Q What's the range?

A They might come for one or two sessions or one or two years or more.

Q On average, how often do you see a client?

A How often? Like once a week you mean?

Q Yes.

A Once a week. Or, no, I'm sorry, not more than once a week usually. It could be -- so on -- so some I might see once every six weeks if they've come a long time and they're just wanting to check in. So I don't know the average, but anywhere between once a week and once a month or once every six weeks.

Q But not usually more than once a week?

A Right.

Q And your therapy sessions, I believe that it's on Defendants' Exhibit 11, the charge is $100 per session?

A Yes.

Q Is that true regardless of how many members of the family partake in the therapy?

A Yes.

Q How long has that been the charge for your private practice?

A Since I started in 2002.

MR. MIHET: Time for an increase.

THE WITNESS: Yeah, principle. I'm not going to out of principle. But you're right, the rates have gone up.

BY MS. FAHEY:

Q So it will -- it sounds like there's no typical length of therapy for your practice, is that true?

A Typical length, right, exactly.

Q Who is the client for you? Is it the family? A particular member of the family? Is it everyone?

A Generally, it would be the family unless just one member -- you know, an individual comes in and I don't see the family.

Q In treatments of minors, that initial phone

call that you get, have you ever had a situation where a minor was the first person to do that initial phone call "We want to come to therapy with you"?

A Not that I remember.

Q How do you structure your sessions -- and let's talk about situations where you have at least one minor as part of the family client. How do you structure your sessions where minors are involved?

A Typically, I will -- I will do what's most comfortable to the family, so I offer -- I usually ask to meet them in the waiting room and say, "How do you guys want to do this? We can either meet all together to start off. We can then split up and I can meet individually with the minor, individually with the parents, or do either of you want to start off individually instead of meeting together?" and I try to get a sense from them.

Sometimes the minor doesn't want the parents in the room. Sometimes the parent wants to come in by themselves so they can tell me what's going on. And sometimes they say, "Oh, yeah, we can go together." So it all depends on what they're comfortable with.

Q What participants do you typically involve in any given session? With the 50-minute session, they come in one week, does it change week to week or is each

week sort of similar?

A It all depends on their needs and their desires.

Q How do you determine who will be involved in each session? Is it completely up to them or do you have any direction as far as "I'd like to speak individually with the minor today"? Something like that?

A Uh-huh. Uh-huh. I sometimes have preferences because I'm not -- I may not be able to get enough information from one member of the family and so it might be helpful to hear from the other members of the family, so I might ask if I could meet with someone. And sometimes they come in really wanting to talk about -- you know, a minor might come in just wanting to use the whole time. Sometimes they're, like, looking at their watch saying to the parent "You only get five minutes. I want the whole time," that kind of thing. So it does kind of depend, but there are times where I do ask "Can I meet with this person?"

Q And what is the youngest age of a minor that you have met with one-on-one without the parent?

A So one-on-one in a session, not for the whole session -- or at any time during the session, even if it's for five minutes you mean?

Q Yes.

A At any time? Six. I'm sorry, I take that back. In my whole career?

Q Let's talk about your private practice.

A What are you talking about?

Q And then you can tell me about before your private practice.

A Okay. And are we talking about clients that were coming in for sexual orientation or gender identity confusion or are we talking about all clients?

Q So if you could just tell me about all clients that you can remember --

A Okay.

Q -- and then you can let me know the second portion; the sexual orientation, gender identity.

A Okay. Okay. So I would not see a child under the age of three, but I would be willing to see a child that's four and up for various issues.

Q And that's --

A And I don't remember if I have or haven't in my private practice.

Q Okay. And so we'll go back to the question of sexual orientation and gender identity in a minor. What is the youngest age that you met with that minor one-on-one?

A Six.

Q What is the expectation for maintaining confidentiality about parent disclosures, child disclosures, and secrets?

A Yes.

Q Can you give me the benefit of your practice?

A Yes. So as a marriage and family therapist, because the family is often the client, the confidentiality needs become kind of unique.

In general, with our clients, we have the same -- we have what's spelled out here, that we are not able to keep certain things confidential: If they're going to hurt themselves or hurt someone else or child abuse or elderly abuse were going on or if we were court ordered to disclose or share a file, so I share that with the entire family.

Then if I meet with family members individually -- and this would include even if I meet with a couple for marriage therapy, if I meet just with the man or just with the woman. Before I ever do that, and before I meet with the minor separate from the parents, before I ever do that I explain to them that "If you share something with me that's going to affect the process of therapy -- for example, if a husband shares that he's having an affair but we're working on

marital issues, it's not -- I can't continue with therapy under the assumption we're working on a marriage when I know that there's a secret affair going on. So I do not go and tell the other parties what you tell me, but I may say to you, 'This is something that probably needs to be shared in order for us to go on. How could we bring this to the other party? What do we need to do? How can we share this?'"

With minors, it's a similar situation where I'll say, "I'm not going to go and tell your parents the things you tell me; however, if you tell me something that is very significant," even outside of, you know, threatening to kill themselves or kill someone else, if there's something -- they're going to run away or they're, you know, doing something illegal, "then I won't go and tell your parents, but I will talk to you about how we together could figure out what we need to do about this and how to get your parents on board with this." My goal is that the family be connected. I believe that's the best thing.

Q Are there any situations -- outside of a child who has threatened suicide or self-harm, are there any situations where you have told a parent "Your child disclosed this to me. They did not want me to tell you this, but I think you need to know"?

A No, I don't think I would, no. I'm always -- I work collaboratively with the parents or the minors, so I would always tell the minor --

Q And everybody --

A -- "What do you think? We need to" -- you know, yeah, I would never just go and tell the parents without talking to the minor first.

Q Do you have communications with parents about the individual sessions that you have with minors? Do you tell the parents "This is what happened in therapy today. They know I'm telling you this"?

A There are times I do that.

Q Do the minors know that you've had those conversations with their parents?

A Yes.

Q What kinds of goals do you typically address with clients when minors are involved?

A Sorry, I was just rethinking my -- I want to make sure I -- your other question, I don't know if I need to elaborate or not.

Q What are you thinking?

A With the telling the parents things, the other thing I would talk about with the parent is direction to go without sharing what the minor has disclosed.

So I just want to be clear, I do not share

what the minor has disclosed without the minor either doing that with me or agreeing to do that when I meet the parents. I help them to know what the needs are without it being any disclosure of what the minor has said. Does that make sense?

Q Yes.

A Okay. So your next question?

Q Do you let the minors know "I have told your parents that you need more this, more attention"? Whatever it is that you might be expressing as a need, do you let the minors know?

A Typically, I'll talk to the minors about what I'm going to talk to the parents about, typically. There may be exceptions to that, but that's my general, yeah, understanding.

Q Okay. And so I had just asked you what kinds of goals do you typically address with clients when a minor is involved?

A What type of goals with the parents? I talk about goals together as a family, and if -- and what are those goals, is that your question? What are the types of goals?

Q Types of goals you address.

A In general with minors and families? Typically, it has to do with there being conflict --

these are some of the goals that might come in. Of course every situation is different.

So, some common goals: Perhaps conflicts within the relationships. It could be just concern for the minor. Maybe the minor is depressed or anxious, social -- having social problems, not doing well in school, any number of -- families have any number of goals when it comes to minor children. It might be helping them cope with a divorce, anything like that.

Q How do you develop the goals?

A I ask the family "What brought you here and what would you like to see happen?"

Q Are there any goals that you have rejected as "That's not a goal that we'll be working toward in therapy. We need to come up with a new goal"?

A I would never say that, and not with -- I can't think of anything with minors, but -- yeah, I don't remember -- I don't actually remember even having a problem with someone's goal once they were in the office, if they're coming to me, but I can't say that's never happened.

I think what comes to my mind is that what we've always been taught in our field ethically is that there are times where it's appropriate to let someone know that you can't help them with their particular goal

because there's a conflict of interest and you won't be able to do that in an unbiased way, and so in those cases you might need to refer them to someone who can help them with their particular goal.

So I don't recall that ever happening, but if it -- that's how I would handle it if something like that came up.

Q Have you ever confronted a situation where your clients were presenting to you a goal that you thought was harmful to the family or not attainable and so, therefore, you guided the goals in a different direction to make it more beneficial to the family or more attainable?

A You're saying have clients, parents or minors, ever had goals that were not beneficial to them in the time that I've done therapy? Yes, probably. I don't remember them, but I would imagine that happens.

Q Okay.

A For example, if a minor child wanted to continue dating a guy who -- a girl wanted to continue dating a guy who's a drug addict and the parents don't want her to, I don't recall that specific situation ever happening, but I've done therapy for 23 years so it's probably there have been situations like that where I think "Oh, dear, that may not be a healthy goal for this

girl to keep dating this person who's really bringing out the worst in her," so I would -- in answer to your question, I would have to say that probably has happened in the time I've done therapy.

Q Generally, what's the approach to that situation? If there's a unhelpful or unhealthy goal, either expressed by a minor or a parent, how do you approach the fact that that goal is something you've acknowledged you don't think is -- "Oh, dear, that's not good for her"?

A Right. So I would think that in my mind, but I would not say that to the client. I would work with the client collaboratively to try to understand: What are the implications of that goal? Is that going to serve you well? Is that -- to try to help them to see if that's really the goal that they want for their lives or not.

Q And so sticking with your hypothetical, if that girl maintained, "Yes, I want to stay in a relationship with my drug addict boyfriend" --

A Yes.

Q -- "that is my goal, will you help me with that goal?" what then happens? Do you assist the minor in maintaining the relationship or do you create new goals at that point?

A You know, it's interesting because therapy is really a conversation that unfolds, so the questions you're asking are kind of more black and white, like we have a goal that we've -- you know, like even said, "Okay. This is the goal that we're working on, and then if we don't agree, let's change the goal and make it something different," but it's such a -- just an interaction between two people, and so there's never really a concrete "Now we're not working on this goal, we're working on a different goal," so I don't -- it doesn't -- I don't think I can --

Does that make sense? It's like goals just kind of -- it's in the beginning, "Why are you here? How can I help you?" but it sort of evolves through a conversation that takes place over time between me and them as a family or them individually.

Q Okay. I don't think I understand what -- what, generally, your practice would be as far as being confronted with a persistent goal of something that you've identified as a therapist that you think is harmful for the girl.

What then happens? Do we focus on other goals in therapy or is there a point where you will then say, "Her goal is to be with this drug addict boyfriend. I will assist her in her goal because she's asking me to"?

A I continue to have conversations with her. I ask her questions. I help her to think through and to process the decisions that she's making, how they're impacting her, yeah. So I don't -- it's not that concrete.

Q Okay.

A It really isn't.

Q Would you be providing her with advice and counsel that would assist her in staying in that relationship? Would that be something you would do in therapy?

A Well, I don't really give a lot of advice or counsel as to what they should do. I ask a lot of questions, I do a lot of listening, and try to help them evaluate and self -- do self-examination, looking at themselves, so I really wouldn't -- I wouldn't say "This is what you should do."

Q Okay. Do you think it would be something that you would do in your therapeutic practice confronted with this situation with the girl who wants to stay with the drug addict boyfriend? Would you ever express to her your thoughts on the potential harmful effects of staying in that relationship? Is that something you would do?

A So psychoeducation is sometimes a part of it,

yeah. "Here are risk factors. Here are" -- yes.

Q Is talk therapy the only form of therapy that you practice?

A Yes.

Q Is your profession accomplished through talking?

A Yes.

MR. MIHET: Form.

BY MS. FAHEY:

Q Do you acknowledge that you have a profession?

A Yes.

Q Is marriage and family therapy your profession?

A Yes.

Q Are there any methods or principles that you use in talk therapy?

A Yes.

Q What are those methods and principles?

A Okay. The power of listening, empathizing, the importance of being nonjudgmental, not shaming clients, creating a safe space where they can open up and share their heart as well as understand themselves better.

Q Are there any particular schools of thought or practice in talk therapy that you would identify

yourself as falling under that you --

A Yes.

Q -- apply this --

A Yes.

Q -- thing?

A So I would say I'm a client-directed therapist.

Q Are there specific principles and methods under the school of client-directed therapy that you particularly use and employ in your therapy?

A Yes.

Q What are those things?

A Joining with the client, putting yourself in their shoes, seeing the world through their eyes, understanding what's important to them.

Q Are those methods that we would say are empirically-based methods?

MR. MIHET: Form.

THE WITNESS: Yes.

BY MS. FAHEY:

Q Can a non-licensed person who does not have an LMFT engage in those methods that you were discussing as falling under the umbrella as client-directed therapy?

A Are they capable of it and able to? Some people are very therapeutic with their friends and

family, so some people do have the impact of making a difference. Are they licensed and legally permitted to call themselves a therapist without that training and degree? No.

Q Is there a difference between the therapy that a therapist such as yourself would provide and the talk principles -- the therapeutic talk that a non-licensed person might provide by talking to friends and family?

A Uh-huh.

MR. MIHET: Form.

THE WITNESS: The only difference would probably be that another thing with the therapist is understanding some of the theories of development and attachment and understanding what some of the contributors may have been to the problem.

So a lay person might know that if they've read a lot of self-help books and therapy books. And they don't have a degree, but they've done a lot of reading, they might be able to do that outside of being a degreed professional.

BY MS. FAHEY:

Q Do you use any medical instruments in your therapy?

A No.

Q The EDMR device that we heard about yesterday with the eye movement, do you have that device in your office?

A No.

Q Have you been trained to employ that type of therapy?

A No.

Q Do you have any tangible things in your office that you use as part of therapy?

A Probably just tissues.

Q How about photographs?

A No.

Q Anything other than tissues?

A I might write down, draw -- I know there's a dating diagram that I sometimes use with single people. That's the only thing that comes to mind. There's probably other things that I've written down in the past, but I don't recall.

Q And you're writing this down on?

A I'll pull out a piece of paper and just -- yeah.

Q Do you have a white board?

A No.

Q Okay. Let's look back at your informed consent. You have Defendants' Exhibit 11. This

informed consent is not particular to any specific therapeutic goal; is that correct?

A Right.

Q Because this is the form you give everybody?

A Right.

Q Okay. And that form, on the second page it has, in the last paragraph, I believe it's the last sentence, it talks about holding harmless the therapist.

A Uh-huh.

Q Why is that there?

A Because all clients -- most clients that are coming into therapy are distressed, and so we know that therapy can -- if they're coming in to talk about their problems that they've been avoiding or ignoring, they might feel worse after they talk about their problems before they feel better. That's just a general idea that --

I mean it's true in in-patient hospitalizations. I mean any type of, you know, treatment for -- you might feel worse before you feel better.

Q Do you advise your clients -- when they identify the therapeutic goal of reducing or eliminating unwanted same-sex attractions, minors specifically, do you advise the parents and the people who are signing on

to this informed consent, do you advise them that sexual orientation change efforts have been questioned by organizations such as the APA?

A If they're coming in for that goal?

Q Yes.

A I do not inform them of the APA. That's not my -- the field that I'm a part of. I'm a part of the AMFT.

Q Do you inform them about any organization that has questioned sexual orientation change efforts?

A I don't. Just like a therapist who's providing affirmative therapy probably doesn't inform their clients that the American College of Pediatricians thinks it's a bad idea for children to take hormones and they don't inform them of the, you know, Christian Medical and Dental Associations' stance on things like that.

So just like those therapists are probably not informing their clients of what other organizations are saying, that's not something that I would need to do, but I do give all my clients an understanding that there's no guarantee that what they're coming for, whether it's depression or anxiety or eating disorders or any other issue, there's no guarantee that they will experience change, and this issue is no different.

Q And do you give specific additional information to clients who are seeking to reduce or eliminate unwanted same-sex attractions, do you give them any other additional information to inform their consent about therapeutic goals related to unwanted same-sex attractions?

A Yes, I do. I --

Q What is the -- oh, I'm sorry.

A Go ahead.

Q What is the additional information that you provide to clients who are, as part of their therapeutic goals, seeking to reduce or eliminate unwanted same-sex attractions?

A I verbally explain to them that there is no guarantee that attractions will change. It is possible that attractions will change, but there's nothing that we can do in the therapy setting to ensure that that is going to take place.

The things that we know are changeable are behaviors -- and these, by the way, are things that are prohibited in the ordinance. Changing behaviors is possible. Changing gender expression, because that's mannerisms from what I understand, is possible.

What the ordinance says we're not allowed to do is change behaviors; gender expression, which again I

think is mannerisms; and gender identity, which is perceptions of self. It is possible to shift behaviors, mannerisms, and perceptions of self, but attractions may or may not shift as we deal with root issues.

And I'm very clear in letting them know that there is no guarantee you can -- and the same is true for depression. There's no guarantee that a person will continue to feel depressed. They may have coping skills that will enable them to know what to do with the depression once therapy is over, but they may still continue to feel badly. This is no different.

Q So in addition --

A But I do explain it. Sorry.

Q In addition to advising them that their attractions may not change through therapy, do you also advise clients whose therapeutic goals are to address same-sex attractions, do you advise them that there is research that has shown that some people experience harm when they undergo sexual orientation change efforts and therapy?

MR. MIHET: Form. Foundation, assumes facts not in evidence.

THE WITNESS: No. The APA's review of the literature -- they claim that there are no studies that show harm -- is that harm takes place in

therapy that seeks to reduce attractions.

So I explain that with any -- pursuing therapy for any issue, you may feel worse rather than better. Some people don't benefit from therapy. And I do explain that the research shows that some people have experienced change both in behavior and in attractions, but there's -- we don't -- we can't guarantee it.

BY MS. FAHEY:

Q Do you specifically address the possibility of harm when you discuss, specifically, efforts to change sexual orientation with clients?

MR. MIHET: Form. Foundation, assumes facts not in evidence.

THE WITNESS: The research studies I have read say that we do not know if it's harmful or not. In fact, that's actually a blatant misleading paragraph in the county's ordinance. It's -- I would call it a lie. It's misleading the public when it says the county commissioners have found an overwhelming -- overwhelming evidence that -- or how did they word it? Anyway, they say --

I will get it out because it's important, if that's okay. Is that okay?

BY MS. FAHEY:

Q Actually, I'd like to know --

A We'll come back to it.

Q Yeah. I'd like to know what it is that you tell the clients. So do you tell the clients that research has not shown that it's harmful? Do you tell them that?

A No. They know based on my consent form that going to therapy, there's no guarantee. And they are saying here that -- they're signing that if harm occurs, that it's -- they're not holding me liable, so they understand that you might get better, you might not. And I'm not going to claim research studies that don't exist about the harm.

Q And my question to you is about what you advise the client. Have we covered the scope of information that you give clients who come to you with the therapeutic goal of seeking to reduce or eliminate same-sex attractions?

A I think so.

Q In your experience, at what age generally -- and I understand it depends kid to kid -- what age do you start to see that a child is able to give you meaningful assent to the therapy that they are receiving?

MR. MIHET: Form.

THE WITNESS: As young as they're able to talk and communicate with you about the subject. Their consent -- so let me back up and explain.

BY MS. FAHEY:

Q Okay.

A Every child is different and every scenario is different, and the child consents in participation. So if a child does not want to participate, they don't talk because it's a conversation.

Q Do you agree that in the therapeutic setting the therapist can be seen as an authority figure to the child?

A Yes.

Q Do you agree that, in general, children often defer to authority figures?

A Yes.

Q Do you agree that authority figures can influence children?

A Yes.

Q So getting back to the question about when you see that the children are able to meaningfully assent to the therapy they're receiving, I have heard your answer to be "As soon as they can participate in the process." Is that a -- is that a correct understanding of what you said?

A Yes. And I probably should add that according to the state of Florida, at 13 they are able to give legal limited consent.

Q And that legal limited consent is limited to crises situations, correct?

A Yes.

Q Do you provide crises therapy?

A It depends. Yeah, there are situations where clients are in crises. I don't have any clients that have come in without their parents, however. But if a child was gravely depressed and needed to be seen, apparently, according to the state of Florida, 13 is the age where they could determine that.

Q And there are limitations on --

A Yes.

Q -- what a therapist can actually do with that minor, how often they can see them --

A How often --

Q -- before actually obtaining parental consent, correct?

A Yes.

Q Have you treated a minor under that statute where you have provided crises therapy to a minor who is 13 or older who comes in to you without their parents' consent?

A Not in my private practice.

Q Have you had that experience at the Spanish River Counseling Center?

A No.

Q Have you ever had that experience?

A Yes.

Q When have you had that experience?

A I worked for Children's Home Society, and we worked with runaway, inhabitable, and truant youth, and so they would sometimes come in as runaways.

Q Were those children that you worked with under that crises provision, were those children seeking help with their sexual orientation or gender identity?

A I don't remember.

Q Is it accurate for me, based on your conversation about the age of consent being the time at which they start participating in therapy, is it accurate for me to couple that with your previous answer of the youngest you have seen is four years old; and with respect to sexual orientation issues and gender identity issues, the youngest you've seen is six years old? So is it fair to couple those two statements together?

MR. MIHET: Form.

THE WITNESS: I guess I would wonder -- just

making sure, what do you mean by "consent"? Because I was answering it according to my idea of consent would be participation, but maybe you meant something else.

BY MS. FAHEY:

Q And so part of my question is I am trying to understand what you're meaning when you say "consent."

A Okay.

Q So participation, if we're going with that, we would go back to your answer about four years old and six years old, is that fair?

MR. MIHET: Form.

THE WITNESS: Yes.

BY MS. FAHEY:

Q Okay. Let's look at some of your interrogatories real quick. They are in this section right here of your binder, and I'll just find it for you. I am going to be handing you your interrogatories. I'm going to be directing you to interrogatory 14, and take a look at that for me. It's on page 12 of your interrogatories.

A I'm sorry. I think I need to go back to what you were talking about a minute ago.

Q Okay. What --

A Or not.

Q What do we need to go back to?

A It seemed like there was an assumption that was being made in the question, so I wanted to clarify that. I don't know if that's appropriate or not.

Q Please.

A It sounded like the assumption was being made that the child is not old enough to give consent to treatment and the parents can't be trusted to decide if the child needs treatment or not. I get that sense even with this ordinance that parents and children are pitted against one another, and that's not how I see families or how I work. And so I want to be very clear that while a child is consenting to participation by participating, we do know, as you pointed out, that parents have authority and they see me as an authority figure, the children do, but I trust the parents to be the parents and to make the judgment on whether their child needs to be in therapy.

If their parents are demonstrating that they are cruel or abusive or hurtful to the child -- if they're abusive, of course that needs to be reported. If they're hurtful to the child but it isn't to the extent of abuse that is reportable, then I work with them on becoming better parents and understanding their child and not pushing their child to do things their

child either isn't capable of or isn't comfortable with.

So I just want to be clear on that. That it really isn't a parent against child, this poor child doesn't have the ability to consent. The child has parents that are bringing them in for help, and the parents are bringing them to a professional who is bound by ethical and legal obligations to do no harm.

So with children, it's -- I think there's this -- it seems like there's this kind of undercurrent of an idea that parents drive children into therapy where they are then shamed, and the truth is if a parent did bring a child into therapy, A, the child can choose not to participate, especially the older they get, the more often they assert their voice, the more boldly they assert their voice; but B, they're bringing them to a professional who is trained in how to listen and empathize and be non-shaming. And so our job is to protect that child and to make sure that child is okay.

So even if they brought the child in against the child's wishes, a licensed ethical therapist is not going to do anything to that child that's going to hurt them. Our goal is to do no harm. So I think that needs to be very clear when we talk about issues of consent and children giving consent. We're talking about consenting to see a professional who is bound by legal

obligation. And of course if harm occurs, that's reportable. But anyway, I just wanted to make that clear. Thank you.

Q Thank you.

A Okay.

Q Did you have an opportunity to read interrogatory --

A Not yet.

Q Okay.

A Which number was it?

Q It's 14.

A Okay.

Q And it refers to psychoeducation in interrogatory 14, right?

A Okay. No. I'm sorry, psychoeducation?

Q Yes. Does it?

A Yes.

Q Okay. What psychoeducation do you provide to parents who are seeking -- who have a minor who has unwanted same-sex attractions or gender identity confusion?

A What psychoeducation?

Q Yes.

A I might give them information to help them understand what some children -- what risk factors some

children have that -- what factors some children have that put them at risk for developing confusion theories.

Q Okay. In the supplemental response to request to produce, Plaintiffs produced PL Joint 811. It's called "A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder." The authors are Zucker, Singh, and Bradley.

A Uh-huh.

Q Are you familiar with that study?

A I'm familiar with those authors and, yes, I would need to refresh my memory, but --

Q In this article, at PL Joint 833, the author states that "Over the years our approach has been a psychoeducational one and also a pragmatic one." He states, "We explain to our parents that there are no empirical studies that suggest that alteration of a child's gender identity will also alter their eventual sexual orientation; B, that homosexuality per se is not considered a mental disorder; C, that gay men and lesbians can lead productive and satisfying lives, as banal as this sounds," says the author, "and that over time, if their child develops a homoerotic sexual orientation, then it will be their job (and ours) to support their child in adapting to whatever stressors may be associated with their sexual identity." Do you

provide that psychoeducation?

A I do not provide that specific psychoeducation.

Q What about your psychoeducation differs from this one?

A That one seems to be imposing values on people, and I'm a client-directed therapist so I go with the values of my clients.

MR. MIHET: Counsel, I'm sorry, the article or the page you just read from is not included in the packet for us.

MS. FAHEY: I know. It didn't print for some reason so --

MR. MIHET: Oh, okay.

MS. FAHEY: -- that's why I just read it out loud.

BY MS. FAHEY:

Q Did you hear what I read as far as the psychoeducation?

A Yes.

Q And were you able to follow what I was saying?

A Yes.

Q Is there something specific that I said that you would not provide as psychoeducation to a parent?

A I just don't provide that to my -- I don't

read that list.

Q And I understand that you might not read this specific list, is there any content in that list that you would not provide to a parent?

A I don't think I provide that content to a parent.

Q Any of it?

A I can't remember the first couple of points.

Q Okay. No empirical studies that suggest that altering the gender identity will also alter sexual orientation.

A I -- I don't -- yeah. Well, so I would probably say it differently, that there's no guarantee that any -- that this is going to change, yeah.

Q And homosexuality is not per se a mental disorder. Do you provide that --

A I don't say that statement, no.

Q Gay men and lesbians can lead productive and satisfying lives.

A I don't, no. I don't say any more -- any of the rest of that list.

Q Okay. So the rest of it you don't say?

A No.

Q I understand that you spoke at the Palm Beach County Board of County Commissioners public meetings.

You spoke at the first reading for the ordinance, correct?

A Yes.

Q And you also spoke on December 19, 2017 when a vote was -- occurred on the ordinance, correct?

A Yes.

Q You also came in 2016 and you made public comments when the ordinance was not even on the agenda, right?

A Yes.

Q Are there any other governmental entities where you went and spoke at a public meeting about the topic of banning sexual orientation change efforts or banning conversion therapy?

A Yes.

Q What other governmental entities did you speak to?

A The city of West Palm Beach, first reading and second reading; city of Delray Beach, second reading; Village of Wellington, first reading and second reading; and I think that's all.

Q How about outside of Palm Beach County, did you go anywhere outside of Palm Beach County?

A Not that I recall.

Q I would like to start getting more

substantively into therapy directed at gender identity issues and sexual orientation issues that you see in your practice, how you practice, et cetera. I'm going to start now with gender identity.

Do you wish to be able to offer therapeutic practices that seek to change a minor's gender identity?

MR. MIHET: Form.

THE WITNESS: So I don't seek to change a minor's gender identity, but I have minors that seek to change or parents of young minors that seek to help them clear up their gender identity confusion, and I believe this ordinance would prohibit me from doing that because it does not specify whether it is the client seeking the change or whether it is me seeking the change, but clearly we work together to accomplish their goals which are now prohibited.

BY MS. FAHEY:

Q And so my question is about the therapeutic practice --

A Okay.

Q -- not specifically about your intent or your individual goal.

A Okay.

Q What I want to know is are you seeking to

offer therapeutic practices that seek to change a minor's gender identity?

MR. MIHET: Form.

THE WITNESS: I --

MR. MIHET: I'm sorry, let me object. Form, foundation, assumes facts not in evidence.

THE WITNESS: I am seeking to help alleviate gender identity confusion.

BY MS. FAHEY:

Q And in part of seeking to help to alleviate gender identity confusion, is part of the practice that you wish to do is to offer a therapeutic practice that would seek to change gender identity?

MR. MIHET: Form.

THE WITNESS: So --

MR. MIHET: Foundation.

THE WITNESS: -- gender identity is a person's perception of themselves, so I would like to be able to provide talk therapy to help little children have a less confused perception of themselves. Does that answer your question?

BY MS. FAHEY:

Q I don't know that it does --

A Okay.

Q -- because I still don't understand if the

therapy that you wish to be able to provide, if that therapy seeks to change the individual's gender identity.

MR. MIHET: Objection. Form, foundation, asked an answered.

THE WITNESS: So the "gender identity," by that you mean their perception of themselves? That's what gender identity means?

BY MS. FAHEY:

Q Okay.

A Okay. I would like to seek to provide therapy to help someone improve their perception -- so to change their perception of themselves if their perception of themselves is that they are the opposite sex.

Q Okay. So it may help us to discuss this more concretely.

A Okay.

Q Let's assume a ten-year-old anatomically female child comes into the office and the parents express that this child is confused and believes that the child is a boy. That ten-year-old anatomically female child says to you that they are confused, they think they're a boy.

A Uh-huh.

Q Are you trying -- is your wish, your intent,

your goal, to be able to offer to that ten-year-old anatomically female child, who has gender identity that could be a boy, are you wishing to provide them therapy that would seek to change that gender identity that is male to a gender identity that is female?

MR. MIHET: Form.

THE WITNESS: Yes, and your ordinance says I can only help them become a male which would include hormones and surgery, very dangerous.

BY MS. FAHEY:

Q Are you authorized to prescribe hormones?

A No.

Q Are you authorized to perform surgery?

A No.

Q Are you currently offering therapeutic practices that seek to change a minor's gender identity?

We'll stick to the example, that's a little bit easier. Anatomically female, ten-year-old child comes in saying, "I'm identifying as male." Are you currently providing to that type of client therapy that would seek to change the male identity to a female one?

A I am not because I am not allowed according to county commissioners, not my state licensing board.

Q We are going to now look at interrogatory 22. You have in front of you the document that you need. I

think you were on 14, so if you could flip a couple of pages to interrogatory 22. And the answer to 22, the substance, is actually on the next page. It's page 18.

Go ahead and take a second to review that, and let me know when you've had a chance to do that.

A Okay.

Q In this interrogatory response you advised that in the nine years prior to the enactment of the ordinance you had these following 11 clients who sought help with unwanted same-sex attractions or gender identity confusion.

Are there any additional clients that belong on this list that are clients who had unwanted same-sex attractions or gender identity confusion, minors, that would span between the time of the ordinance and today?

A No, because I'm not legally permitted.

Q So on this list it appears that there are only two individuals who you have seen in the last nine years with gender identity confusion. Does that appear accurate to you?

A Yes.

Q And I'm looking at specifically Doe 1 and Doe 5.

A Yes.

Q And Doe 1 is a six-year-old client?

A Was in the past nine years.

Q Okay. And so that age, does that refer to the age at the beginning of therapy?

A Yes.

Q Okay. And Doe 5 began therapy at age ten?

A Yes.

Q I'd like to refer you to your complaint and it -- I'd like to ask you specifically about paragraph 153. If you could read that, you don't have to read it out loud.

A Okay.

Q Does paragraph 153 refer to Doe 1, Doe 5, or another person?

A Doe 1.

Q When did you begin your relationship with Doe 1? Approximately what year?

A I don't remember.

Q Is Doe 1 someone that you saw at Spanish River Counseling Center or in your private practice?

A Private practice.

Q Are any of the clients listed 1 through 11 individuals who you saw at the Spanish River Counseling Center?

A No. It only goes back nine years. I've been in private practice for 16.

Q Is Doe 1 a current client of yours?

A It is an open case, meaning the case has not been closed.

Q When is the last time you saw Doe 1?

A I don't actually remember.

Q Have you seen Doe 1 in 2018?

A I'm not positive.

Q And in paragraph 153 you mentioned that the child, Doe 1, was demonstrating a discontentment with the child's biological sex. What does that mean? And when I ask "what does that mean," not like what does discontentment mean, but what does that mean for the child? What was the demonstration of that discontentment?

A Typically, when children demonstrate that, they are dressing like the opposite sex. They are playing with opposite sex toys. They are not interested in toys that their peers would be interested in. They are showing outward signs of identifying more as the opposite sex than as their own sex.

Q Are all of those things true for Doe 1?

A I forgot what I just said. I know I said dressing and I said playing with toys.

Q Identifying --

A I'm not sure that it was to that extent. I

don't know if I said -- do you want to read back what I said? Is that okay?

Q Sure.

A I don't know if I said they weren't playing with toys of their own sex or not.

THE COURT REPORTER: "Typically, when children demonstrate that, they are dressing like the opposite sex. They are playing with opposite sex toys. They are not interested in toys that their peers would be interested in. They are showing outward signs of identifying more as the opposite sex than as their own sex."

THE WITNESS: So your question was: Was this child doing all of that? Yes, but perhaps not to the fullest extent.

BY MS. FAHEY:

Q Okay.

A Okay.

Q Did this child, Doe 1, have a diagnosis?

A No, because I don't use diagnoses in my clinical practice, but someone else may have diagnosed them if someone that thinks in terms of diagnoses may have. They may have fit the criteria for a diagnosis.

Q Were you aware of any other provider who had given Doe 1 a diagnosis?

A No.
Q Who set the therapeutic goal for Doe 1?
A It would have been the parents and the child.
Q And can you please describe to me -- I know you don't even remember when you saw Doe 1, would you please describe to me your recollection of how Doe 1 participated in setting the therapeutic goal?
A I don't remember the very first session when I asked the question "What brings you here? How can I help you?" And then from there, like I said, it's not a concrete "Now what is our goal today?" it's just an evolving conversation. So I would have to remember the first conversation I ever had in order to tell you exactly how they participated, so I don't remember that.
Q Was Doe 1 distressed about -- have you disclosed whether Doe 1 is a male or female --
A No.
Q -- anatomically? Okay. Was Doe 1 distressed about identifying with the opposite gender, playing with opposite gender toys, and dressing opposite gender?
A I don't remember if there was distress or not.
Q I see you're checking back with 153. Let me know when you're finished reviewing that, okay?
A Okay. It says here the parent initiated therapy due to their concerns. Sometimes children that

young don't articulate "I'm worried about myself. I'm not really aligning with myself in the way that I should be."

Q Okay.

A So I think if that's what you mean by "distress," it looks to me like it wasn't the child that was saying "I have a problem."

Q How would we know that the -- in this situation of Doe 1, that Doe 1, at six years old, assented to the therapy that Doe 1's parents wanted for Doe 1, which was to address the fact that they were not wearing the clothes designated for their sex, playing with the toys designated for their sex, or identifying as their anatomical sex?

MR. MIHET: Form.

THE WITNESS: How do we know that the client consented? Because the client was happy to come in, willing to talk, participate, yeah.

BY MS. FAHEY:

Q Was Doe 1 aware of the therapeutic goals for Doe 1?

A I would imagine, yeah.

Q In paragraph 153, I know you just had a chance to look at that again, it states that "The gender identity confusion appears to be decreasing

dramatically."

A Uh-huh.

Q To what did you attribute the decrease in Doe 1's gender identity confusion?

A When children become more comfortable with themselves and feeling more at home in their bodies.

Q When you use the term "gender identity confusion," are you referring to a person whose anatomical sex we'll say, for example, is male but they identify as female?

A Yes.

Q Does that gender identity confusion apply -- for your vernacular that you've used --

A Yes.

Q -- does that apply to every situation where an anatomical male identifies as female?

A Would I use that phrase for every situation? I would not use that phrase. I think as a child becomes a teenager or an adult, they would identify themselves as transgender, so that would probably be the term that I would use. But for a young child who's still developing and evolving, I wouldn't put a label on them like that.

Q Okay. And what I'm wondering is do they always get the label "confusion" if they're identifying

with the sex that's not their anatomical sex?

A Well, I don't tell them that they're -- I'm using that label for you to understand --

Q Okay.

A -- what we're talking about, but I would not tell a child. I wouldn't put a label on a child at all.

Q What interventions were employed in the therapeutic treatment of Doe 1?

MR. MIHET: Form.

THE WITNESS: So typically how I work with all of my clients is it's a family approach. So the younger the child, the more time I will spend with the parents talking about their role in cultivating a deeper relationship, connecting with the child, helping the child to feel confident and comfortable with who they are. I spend a lot of time with parents when they're that young.

BY MS. FAHEY:

Q And what do you do with the child? And did you ever meet with Doe 1 individually without the parents?

A Typically when children are young, I meet with them -- when they're that young, I meet with them simply to understand what they're thinking and where they're coming from. And so I spend, when they're that young,

anywhere between five or ten minutes to maybe a little bit more than that, but generally to understand their perceptions of themselves and perceptions of their experiences that they've had and perceptions of their relationships with their family, their parents.

Q And through this time that you're spending the five to ten minutes understanding them better, are you also doing anything that would be treating the child's gender identity confusion?

I'm not a therapist, I don't know what the options are. Things that I can imagine may be encouraging them "Why don't you try on a dress. What did you think about putting on these little shoes? Aren't they very pretty? Here's a doll. Do you like the doll? Why don't you try to spend more time with mom or dad?" I truly do not know, but just as a way of what I'm trying to figure out is are there -- other than just gaining information --

A Uh-huh. Right.

Q -- are you giving any information, are you doing anything with that six-year-old Doe 1 that --

A Right.

Q -- would be a therapeutic practice to try to assist in the gender identity confusion?

A Okay. Right.

MR. MIHET: Form.

THE WITNESS: So one of the ways that I work, as it was stated, client-informed, client-directed, solution-focused, that's another approach to therapy that was taught in my master's and Ph.D program.

So with client-directed therapy, you're seeking to understand the client and elicit their resources and their strengths and their abilities and also understand their perspective and where they're coming from.

The solution-focused part of that would be using the things that -- not only using their resources that they have to help them, so you're digging to understand what the resources are, but also building on their strengths and building on the things that are already working well. So in addition to gaining information from the client, I will talk to clients about "Are there times that this is not a problem?" I won't necessarily use those words, whatever the problem is. "Are there times that you feel confident as to who you are and in your own skin? Do you like being who you are? So tell me about those times." And so we would talk about building on the times that -- or the

experiences that already are going well for them.

So I might say, "Homework, for example, might be between now and next time you come in try to note all the times that you were feeling most at home in your body or most comfortable and let's talk about that next time. Tell me all the times you discover that you're feeling good about who you are." That kind of thing would be an approach that I might use with a child.

BY MS. FAHEY:

Q Is there anything, sticking with Doe 1, is there anything in the individual -- I know they're short, five to ten minutes that you would spend with Doe 1. Is there anything that you are doing to affirm that child's anatomical sex in the talk that you do with that client?

A I'm not sure if there's -- I'm not -- yeah, probably -- I mean, yeah, I don't know.

Q Is there anything that you do in that individual 10 to 15 minute session with Doe 1 that would be to downplay or reject or in any way try to show some sort of like "I'm not sure that's really what we need to be doing as far as the identification with the opposite anatomical sex"?

MR. MIHET: Form.

THE WITNESS: Because I'm more of a strength-based therapist, I typically won't tell clients, "Oh, you shouldn't be doing that" as much as I would try to build on whatever is there that's going well.

So if a client showed me a picture of her in a dress for Halloween or whatever, "Oh, you look so beautiful." So if the word "beautiful" is reinforcing -- that's why I said I don't know what's reinforcing who she really is but -- so that's -- that's what I would do is I wouldn't say "Don't do that. That's not who you really are." That's not really my approach.

BY MS. FAHEY:

Q And is the goal in identifying times when the child feels good in their anatomical body, feels good about who they are, is the goal of doing that homework and having that conversation, is that goal to assist them in changing their gender identity from -- let's say they're anatomically female, so changing their gender identity from male to female, is that the goal?

MR. MIHET: Form.

THE WITNESS: The solution-focused -- that approach with solution-focused therapy, the goal is you find the exceptions and you build on those

exceptions. And as you help the client to continue to see the strengths or the times that life is working well in the way that they want it to work, that that will expand the more they're looking for and discovering and attending to those times.

BY MS. FAHEY:

Q Approximately how many sessions have you had with Doe 1?

A I do not know. I have no idea.

Q I know you don't remember when you started your therapeutic relationship with Doe 1, ballpark, would it be more in the category of a few months, a few years, a few weeks?

A A couple of years. Uh-huh.

Q And this file is one that remains open for you?

A Yes.

Q Is it fair to say that you have not terminated your relationship with this client?

A That's right.

Q Have you substantially changed your relationship with this client?

MR. MIHET: Form, asked and answered.

THE WITNESS: No.

BY MS. FAHEY:

Q How, if at all, has your treatment of this client changed since the passage of the county's ordinance?

MR. MIHET: Form, misstates the client's prior testimony.

THE WITNESS: Well, thankfully, by the time the ordinance was passed they were not coming in for the goal of changing anything, so I did not have to change what I was doing to accommodate this ordinance.

BY MS. FAHEY:

Q So prior to the enactment of the ordinance would you say that your therapeutic practice, your treatment of Doe 1 was seeking to change the gender identity from what it was to what it now is?

MR. MIHET: Form, assumes facts not in evidence.

THE WITNESS: Changing the gender identity from what it was to what it now is, I would probably say it differently. I would say helping the child to be more comfortable in [redacted] own -- in the child's own skin. Would you omit the pronouns for public record? Okay.

BY MS. FAHEY:

Q Okay. And I understand you would say it

differently, but the goal of the therapy was to help the child identify not as they were identifying when they first came in, but to identify and perceive their gender to be their anatomical sex?

MR. MIHET: Form.

THE WITNESS: To help them --

MR. MIHET: I'm sorry. Form, assumes facts not in evidence, asked and answered.

THE WITNESS: To help them be confident in their anatomical sex, yes.

BY MS. FAHEY:

Q Okay. Let's talk about Doe 5.

MR. GANNAM: Before we do that, before we go to another patient, can we go ahead and take a break?

MR. MIHET: Yes, please.

MS. FAHEY: Sure.

(Thereupon, a short break was taken from 11:26 a.m. to 11:37 a.m.)

BY MS. FAHEY:

Q So I said before we were going to move on to Doe 5, just a couple more questions about Doe 1. How do you measure the success for assisting the minor in eliminating their gender identity confusion? How do you measure that?

A If the minor is describing or -- and/or appearing more comfortable in their own skin.

Q Are there times when you have helped a child be more comfortable with a -- with perceiving themselves as a gender that is different than their anatomical sex?

A Helping a young child be more comfortable?

Q What do you define as "young child"?

A Under the age of 12, 12 and under.

Q Okay. So have you ever done that for a child under the age of 12?

A No.

Q Have you done that for a child between the age of 12 and 18?

A Not help them be more comfortable, but I've had teens identify as transgender not seeking to change, so we don't seek to change it.

Q Are there any times when you would approve or agree that a child should transition to be the gender that they are identifying with but that differs from their anatomical sex?

MR. MIHET: Form, assumes facts not in evidence.

THE WITNESS: You asked if there was ever a time that I would help a child -- suggest that a child transition?

BY MS. FAHEY:

Q Approve or agree and assist in the transition therapeutically.

A The research is quite clear that hormones have very serious side effects and that removing body parts is probably not a decision that should be made early -- even into early adulthood the brain is still changing, and so into the early 20s. And so to even --

No, I would not encourage a child -- children are developing and their brain is continuing to develop into their early 20s. I would not encourage a child to take permanent steps to change their bodies in a way that would produce major side effects. No, I would not encourage that.

Q And if we were to not talk about permanent changes as far as surgical or physical change such as hormonal supplement ingestion, but just change social identity as far as going to school and asking for a different pronoun to be assigned to them, maybe going by a different name or maybe dressing differently, would those be things that you would approve of or agree or assist someone with? Is there any situation that you can think of that you would find that appropriate therapeutic practice for you?

MR. MIHET: Form, foundation, assumes facts

not in evidence.

THE WITNESS: The research shows that a high percentage of children with gender identity confusion will naturally grow out of it. Those children that do grow out of that don't end up identifying as transgender. They may end up as identifying as gay or bisexual or lesbian, but they do not continue to identify as transgendered. I believe it's around 80 percent of those children grow out of identifying as transgender; however, the ones that are encouraged, as you're describing down that path, do not typically outgrow it.

I believe, and I'm not positive, but I believe the research shows a very high percentage, maybe 90 or more, of the ones that are encouraged to go ahead and wear a dress and identify as the opposite sex continue down that road. Let me just make sure I said that clearly.

BY MS. FAHEY:

Q Okay.

A Without intervention, most of those children would outgrow it; however, the ones that are encouraged to go ahead and start pursuing that in childhood will often not outgrow it.

Q And what does that mean for your practice?

A It means that I would not suggest something that I believe would be detrimental to a child.

Q Do you view persistence in a gender identity that is different from one's anatomical sex to be harmful?

A If the persistence leads them to take puberty suppressing hormones usually around the age of nine or ten, I would say that's pretty harmful.

Q And let's just go back to the situation where no hormones are ingested or injected and no surgery is undergone, just the child who may be dressing differently and identifying differently socially. Is that something -- I'm trying to understand if the persistence of a gender identity that differs from one's anatomical sex is viewed by you, in your practice, to be harmful?

MR. MIHET: Form.

THE WITNESS: If the persistence leads to hormones, so you're asking if I would encourage them to identify as the opposite sex, there's a risk that doing that would lead them to taking hormones by -- I mean they can do that as early as nine. So if I was encouraging them, "Go ahead and identify differently at school and start wearing a dress," most likely the next step, if their parents

allow them to take those steps, would be towards hormones, so I would not want to guarantee something that would be -- and let me say not most likely, but there is a chance that it could lead to medical interventions if they're going to go as far as socially changing their identity.

BY MS. FAHEY:

Q Do I understand your professional practice correctly when I -- I'm trying to synthesize the information that you gave me.

A Okay.

Q That you would not encourage a -- doesn't matter the age, you would not encourage a minor to identify as a gender other than the one that matches their anatomical sex because that would increase the likelihood of persistence, and the likelihood of persistence makes it more likely that they would undergo hormonal intervention or surgical intervention which -- and it is the hormonal intervention and surgical intervention that you view as harmful?

MR. MIHET: Form.

THE WITNESS: Okay. There are a lot of aspects to that probably, so I don't know how much -- do you want a short answer or --

BY MS. FAHEY:

Q I'm trying to identify if there's ever a situation where you would encourage the identification of a child with a gender other than the opposite sex.

A Okay.

Q And the information that I understand to have received from you is associated with concerns about hormonal therapy and surgical therapy.

When we removed that and we talked only about social change, it sounded as though hormonal intervention and surgical intervention remained a concern for you.

A Uh-huh.

Q I put those together in my mind to believe that there is no situation where you would encourage or approve of social identification with a gender that is different from your anatomical sex because of those other things. And so --

A And I will say --

MR. MIHET: Let her finish --

THE WITNESS: Okay.

MR. MIHET: Let her finish the question.

THE WITNESS: Okay.

BY MS. FAHEY:

Q And so there may be other reasons why you just wouldn't encourage it at all. I am trying to figure

out, and I don't know if I have the answer, is there any situation that you can imagine, based on your experience of situations you've encountered, that in your therapeutic practice you would in fact approve or encourage a minor, adolescent or young child, you would encourage that minor to identify with a gender that is different from their anatomical sex?

MR. MIHET: Form.

THE WITNESS: Yeah. So the basic premise of my practice, as stated on my website and I believe it's stated in other places on my website more succinctly, but it says that I strive to help people connect -- no, I'm sorry. It would be -- let's see. Oh, when we're disconnected, we experience -- somewhere else on my website it is -- I state that I help people connect more deeply with themselves, God, and one another. So the whole underlying premise of my work is helping people to be connected, helping them to be at home inside their own bodies, connected with who they really are, and connected with others in good, healthy life-producing relationships -- fulfilling relationships, and then connected with God if they're interested in spiritual aspects.

And so what you're saying about -- what you're

suggesting is helping a child be the opposite sex, does not fit with the ideas that I believe and hold deeply. That is, when we are connected to ourselves, the true self that we are, we're most healthy, and so I -- now that's -- so it doesn't fit. However, I have had clients who said that they were transgendered and I do not try to talk them out of it if they are teenagers who are certainly set on that. Children, young children, don't usually have an adamant -- well, I'll say it this way: Young children are often still very, very impressionable and so there's a lot more openness with younger children than there is with an older identifying.

So I will not try to talk someone out of it depending on their age and their situation and the depth of how strongly they feel that -- whether it's just a phase or it's something that they really -- a deeply-held belief that they have, I won't try to talk them out of it, but I also would not encourage someone to detach from who they are.

BY MS. FAHEY:

Q Do you believe that it's possible that -- and I am asking about your beliefs and how it informs your therapeutic practice. Do you believe that it's possible

that a person has the anatomical sex of a male but they truly are a female?

MR. MIHET: Form.

THE WITNESS: According to the research, there is no scientific basis for that. What we know right now is that there are people who perceive that they are different, just like a woman with anorexia might perceive that she is fat when she is really skinny. People have different perceptions of themselves, but we have never -- there is no research that would tell you that people are actually born in the wrong body anatomically.

BY MS. FAHEY:

Q Let's talk about Doe 5.

A Okay.

Q And Doe 5 is identified by you in interrogatory 22 to have begun therapy with you at the age of ten, okay?

A Okay.

Q Do you recall when you began therapy with Doe 5?

A I do not.

Q May I please direct you to paragraphs 157 and 158 of your complaint because my question to you will be: Is the person described in these paragraphs Doe 5?

A 157 and 158?
Q Yes, ma'am.
A No.
Q Did you describe Doe 5's situation in your complaint? Do you recall?
A No.
Q Did Doe 5 have a diagnosis?
A No.
Q Who set the therapeutic goal for Doe 5?
A I honestly don't remember.
Q Do you remember what the therapeutic goal for Doe 5 was?
A This one was a long time ago.
Q Okay.
A I do not.
Q Is the file for Doe 5 closed?
A Yes.
Q Was it closed before the enactment of Palm Beach County's ordinance?
A Yes. Years ago, yes.
Q You have indicated that none of your clients had the single therapeutic goal of addressing unwanted same-sex attractions or gender identity confusion; is that correct?
A None of my clients have ever had that single

goal?

Q That that was the only goal presented in the therapeutic context.

MR. MIHET: Form.

THE WITNESS: I don't remember saying -- you're saying that in all the years I've practiced, I never had a client with a single goal of --

BY MS. FAHEY:

Q I'll find it so that we're on the same page with that.

A Okay.

Q So if you could -- you have in front of you the interrogatories, and you're on page 18. If you could flip to page 17, and I'll show you where I'm at. I'm at the bottom of the page. There's the word "Response" in bold.

A Uh-huh.

Q Do you see that?

A Uh-huh.

Q It says, "Hamilton does not have clients whose only goal is to reduce or eliminate unwanted desires as stated in the interrogatory."

A Does not have that -- those clients right now currently.

Q Okay. So was Doe 5, to your recollection, one

of the clients whose only goal was to address gender identity confusion?

MR. MIHET: Objection. Asked and answered.

THE WITNESS: It was years ago. I honestly don't remember.

BY MS. FAHEY:

Q Okay. What do you remember about your therapy of Doe 5?

A So just a side note here. In collecting all of the data to answer these questions, I had to go back through my file cabinet years back and so -- you know, it's hard to remember these things, and so I was able to write -- answer your questions, but I don't have a lot of details on the clients that are older clients.

Q Okay.

A Okay. So what do I remember about Doe 5? What I recall is two parents and a child that was not secure in [redacted] gender but -- in the child's gender, but I don't -- I don't know that it was a -- from what I'm recalling, it wasn't wanting to be the opposite sex, it was just lacking security with confidence, confidence in fitting in with [redacted] --

Or, you know, what happens is a child -- when I say "lacking confidence in their gender," so a child who feels different from other members of that same sex

and feels that they're not on par with the peer group, maybe they see themselves as -- not as masculine or feminine as maybe the cultural expectations are or as their peer group expects, and so I believe that case was about that.

Q Hypothetically, let's say Doe 5 is a male, hypothetically.

A Okay.

Q Not actually.

A Okay.

Q Hypothetically, if Doe 5 is a male, do you recall whether Doe 5 had reached the point where Doe 5 was identifying as a female?

A No, was not.

Q Just insecure in the male identity?

A Yes. Right.

Q Do you recall what the outcome of your therapy with Doe 5 was? Were you able to assist Doe 5 in becoming more secure, hypothetically, as a male?

A I believe, but I think that was a shorter -- shorter term case, which is why I don't have a lot of recollection. Sometimes when you see them for a long, extended period of time you remember a lot more, but this one I don't think went as long.

Q Well, since Doe 5 was ten years old as opposed

to the other client being six years old, did you meet with Doe 5 either more regularly or for longer intervals of time than you did the younger client who had gender identity confusion?

A I actually don't think so. I think I met more with the parents.

Q Okay. So based on the previous answers, is it fair to say that if you met with Doe 5 alone, it would be no more than that 10 to 15 minutes that you were talking about previously?

A I would think so.

Q And I know your memory is shaky on this one in particular.

A Yeah.

Q With respect to Doe 5, do you remember what it is that you were accomplishing in those 10 to 15 minutes with Doe 5?

A That I honestly do not remember what we talked about. It may have been perceptions of the parents, could have been.

Q How do you define what is a closed file and what's an open file?

A If a client is no longer returning or planning to return, it's closed, but clients could return ten years later and then I reopen, so that happens. And if

they -- so they're closed if they're no longer coming at this time in their lives and reopened later. The ones that are left open is because they may come back. Not all of them do. If they don't --

The way I leave it with clients is it's always up to them. If there's a need to continue, they continue it. If there's not, I don't tell them, "Okay. We're done." It's more of "Have you gotten to where you want to be?" And so oftentimes when people are doing well, I'll say, "Okay. Well, if I don't hear from you, I'll assume things are going well," so we kind of leave it like that and then eventually I'll close the case because they, you know, went on to live happily ever after, so to speak. We hope.

So, anyway, I have some open cases that I have not seen them in a month or two months, but there's a chance they could call me, you know, next year. People kind of are in and out sometimes. Some come every single week and it's very regular and others it's more of a check-in, kind of like a tune-up for your car or something like that, so yeah.

Q About what is that time frame when you haven't seen them for, hypothetically, six months? Like what's the mark that you say, "I'm going to go ahead and close this file in my system now"?

A Yeah, I don't actually have one.
Q Okay.
A It would probably be when I have time to go through files, truthfully.
Q Okay. And I know you don't remember when you began the relationship with Doe 5 --
A Right.
Q -- and the family of Doe 5. Do you recall when it ended? A year?
A No. I think it was a handful of sessions.
Q Okay.
A Maybe months, spanning months because I don't think it was weekly but...
Q And I am curious if you know if it -- so if it didn't go that long, it would have been generally within the same year?
A Right.
Q I'm wondering if you would be able to tell me "That was in 2015" or anything like that.
A With that one I honestly can't. Sometimes I really do remember dates, this one I don't. And I'm guessing when I say a handful. I think it was -- I would guess it was around five or less, but it could have been more. I honestly don't remember with this one.

Q Do you know why your therapy with this client was on the shorter end it sounds like?

A Sometimes you have people that are super committed to coming and sometimes -- families I'm talking about, the family as the client -- and sometimes with -- as with anything, people get busy, they don't want to spend the time or the money, and so you have people that come for shorter amounts of time because of that, or you have people that come for shorter amounts of time because they accomplished their goal and they really don't need to come anymore.

So with them, I don't know. I don't remember if it was "Okay. We're in a good place. We're ready to stop" or "Life is too hectic and busy, we just can't continue to come." It may have been both. Sometimes people stop coming. It's not a priority anymore when things are less intense, like less of a problem. You know, when the pressure's on, that's when they come. When they're seeing problems in their family, they come in. And then if the problems subside somewhat, they stop coming whether they've attained their full goal or they're just feeling better and partially to their goal. Yeah, so it's hard to always know.

Q Okay. I am next going to be talking about your clients who have unwanted same-sex attractions and

behaviors and sexual orientation change clients and practices.

Before I move on to that category of treatment and patients, is there anything else that you wanted to clarify or let us know about your treatment of gender identity confusion?

MR. MIHET: Form.

THE WITNESS: No. I mean I would just say -- I don't know. I probably wouldn't word it as "treatment of gender identity confusion." I would say the ways that I help people, which is through talking to them and conversations with them, I -- and it's usually with the family. If it's, like I said, under 12, it's more with the parents on how to relate and connect more deeply with their child so their child can be connected to themselves.

It's very much about fostering deep, meaningful, close, loving relationships between the parents and the child. That is the focus of the work under the age of 12 so -- and it's conversations again, not really treatment. That seems to imply something different than what I do.

BY MS. FAHEY:

Q Okay. Is there anything else that you would like to share about the conversations that you will have

in your therapeutic office in your private practice about gender identity confusion?

MR. MIHET: Form.

THE WITNESS: So just -- no. Just what I had said about it's mostly directed at helping parents deeply connect with their children in a nurturing way that inspires the child to feel connected and at home within themselves.

BY MS. FAHEY:

Q Before the passage of Palm Beach County's ordinance December 19, 2017, did you provide therapy that sought to change the sexual orientation of a minor?

MR. MIHET: Form, foundation, facts not in evidence.

THE WITNESS: So "that sought to change," it's a broad term that I am not exactly sure what that means because I don't actually seek to change people, but what I read from the ordinance definition, you know, the way that kind of is worded, does it mean therapy that is helping people accomplish their goal of trying to change attractions or behaviors?

BY MS. FAHEY:

Q I'm asking you if your therapy --

A Uh-huh.

Q -- if the therapy you provided --
A Uh-huh.
Q -- if that therapy --
A Uh-huh.
Q -- sought to change the minor's sexual orientation. And I think sometimes it's helpful for us to use hypotheticals, so we'll say hypothetically there's a minor, we'll say 15 years old. That minor is identifying as a gay minor.
A Okay.
Q Did you -- hypothetically, were you providing therapy that would seek to change that gay minor's sexual orientation to a heterosexual orientation?
MR. MIHET: Form, facts not in evidence.
THE WITNESS: So -- okay. I don't seek to change orientation because orientation refers to attractions, how that client is oriented, whether they're oriented towards the same sex -- whether they're sexually oriented towards the same sex or the opposite sex. So my goal is not to change their attractions but to deal with underlying issues that often may lead to their attractions diminishing or decreasing or being altered in some way, and also assisting clients in changing their behaviors or other things in their life that they

are stating is their goal to change. So, yes, I've had clients like that.

BY MS. FAHEY:

Q And were you providing therapy that the purpose of the therapy was to change the sexual orientation, sexual attractions from homosexual attractions to heterosexual attractions?

MR. MIHET: Form, facts not in evidence.

THE WITNESS: I don't know. So if a client comes in and says "I'm attracted to the same sex," I don't try to help them change their attraction -- I don't say "Because of this therapy, you will no longer be homosexually-oriented, you will be heterosexually-oriented." That is not possible for me to promise to do for a client.

We know from the research that sexual orientation does change for some people. Their attractions can change and their behaviors can change, but not everybody experiences change and not even everybody that wants to experience change in attractions will. Anybody that wants to change their behavior typically can, but not attractions. Just -- so there's no guarantee that attractions will change, but they can change.

So I do not provide services aimed at changing

sexual orientation. I provide services -- I provide talk therapy aimed at helping people understand themselves, understand what their attractions are all about. Sometimes that results in the attractions being diminished or reduced.

I help people change their behaviors. I help people change their perceptions of themselves, but I'm helping them accomplish their goals for their lives.

BY MS. FAHEY:

Q I think I understand the distinction you're making --

A Okay.

Q -- and so I'm going to ask -- I'm going to say something and see if it's true or not true for what you were doing. Okay?

A Okay.

Q So I think I understand you to be saying that -- and we'll talk about prior to the passage of the ordinance.

A Okay.

Q You would provide therapy that sought to change an individual's behaviors?

A Sought to help them change their behaviors.

Q Okay. But the purpose of the therapy was not

to change their attractions?

MR. MIHET: Form.

THE WITNESS: Okay. Okay. There are clients who come in saying, "I do not like being attracted to the same sex." What I'm telling you is that I don't provide some type of, quote/unquote, treatment or therapy that aims to change their sexual attractions. I aim to deal with the deeper issues knowing that, as a result, those attractions may change.

So, yes, I help clients accomplish their goals of -- and maybe some people put it this way, exploring their heterosexual potential or exploring the potential for their attractions to change. Does that make sense?

BY MS. FAHEY:

Q I'm wondering if prior to the passage of the ordinance you would say "Yes, I do that" or "No, I don't" as far as were you providing therapy that was an effort to change sexual orientation?

MR. MIHET: I'm going to object to form, and the question has been asked and answered several times. I'm not sure the answer is going to change if you keep asking the same question but --

THE WITNESS: Prior to the passage of the

ordinance I had clients who came in saying, in different ways, different clients -- so you're talking about in all the years that I've worked prior to the passage of the ordinance? Is that what we're talking about?

BY MS. FAHEY:

Q Yes.

A Okay. I have had clients who came to therapy because they were distressed by unwanted homosexual attractions and behaviors, and I have offered to help them work through that distress and figure out what could be accomplished.

Q Have you offered to help them change their sexual orientation?

MR. MIHET: Form, asked and answered.

THE WITNESS: No, I don't help, but here's the thing: I don't offer "Let me help you change your sexual orientation" because it doesn't work that way. I can't change your attractions. I can help you figure things out in your life and talk through things and process things and understand how to change behaviors, and as we're dealing with root issues, sometimes those attractions will change as a result.

And I have had clients that I have assisted

who had unwanted homosexual attractions and behaviors, clients that are now prohibited by your ordinance from coming into my office and getting help. I have helped them in the past, and they are no longer allowed to come into my office and get help, and I am no longer allowed to talk to them about these issues that distress them.

BY MS. FAHEY:

Q I think I understand you to be saying that there is no effort on your part that you can do to change someone's sexual orientation. Is that something you agree with?

A By "sexual orientation," you mean their attractions?

Q Yes.

A I can help that -- their attractions may change in therapy.

Q That's fine.

A Okay.

Q I want to know is there something that you want to do, claim to do, think that you could be able to do that would be an effort on your part as a licensed therapist to change sexual orientation?

MR. MIHET: Form, asked and answered.

THE WITNESS: There are efforts that we make

in therapy through our conversations that may result in a change of attractions, they may, and the client knows that --

BY MS. FAHEY:

Q Okay.

A -- "I'm not going to be able to change your attractions, but your attractions may change as we deal with the issues at hand."

Q So I understood earlier, when we were looking at your consent form and you were letting me know that sometimes people may feel more depressed talking --

A Uh-huh.

Q -- you know, through therapy --

A Yes.

Q -- certainly you're not in an effort to make anybody feel more depressed --

A Right.

Q -- even though that may be a side effect from what you're trying to do, right?

A Okay.

Q So it sounds to me as though you're saying that it may be a side effect of what you're trying to do, that an orientation may change.

A Okay.

Q I don't know if you're saying that --

A Okay.
Q -- or if what you're saying -- now I'm not trying to harass you or figure out like -- I'm truly trying to understand --
A Okay. Okay.
Q -- is this a side effect you're talking about --
MR. MIHET: Let her finish.
BY MS. FAHEY:
Q -- is this a side effect you're talking about or is this you are doing something for the purpose of hoping that the client can get there to change their sexual orientation?
Now because I know you're not saying "I can change their sexual orientation," but it sounds like you're saying "I can do some things and maybe sexual orientations change." So is that like a goal of what we're doing or is it this unwanted side effect such as increased depression?
A Okay. Thank you for the clarification.
MR. MIHET: And let me object as to form.
THE WITNESS: Okay. So it is a desired outcome that the client has, but the client knows, from me directly, that you may not ever have that outcome. Your attractions may persist, just like

someone with an addiction may continue to crave alcohol but choose not to drink. They may continue to crave it. Your attractions may persist but maybe to a lesser degree, or maybe they'll go away like the craving for alcohol and then maybe come back during a time of stress, or they may fluctuate throughout your life.

Most likely the things that we have in our lives don't disappear forever, never to return again, and that's true of every issue that we deal with. Whether it's a person who is chronically late or a person who has a shopping addiction or whatever it is, we can improve, but that doesn't mean we'll never, ever, the rest of our lives, ever experience that problem ever again. And so that is made clear to the client when we embark on the goal of changing their behavior and hoping to reduce attractions, if at all possible.

BY MS. FAHEY:

Q And is that a therapeutic practice that you would like to be able to offer to minors?

MR. MIHET: Form.

THE WITNESS: Absolutely. Sorry. Yes. And I am not allowed because the county has prohibited me from having conversations with clients that would

help them explore their heterosexual potential or their potential for decreasing attractions, having their attractions decrease, or even changing their behaviors.

BY MS. FAHEY:

Q Now the examples that you were giving me talking about alcoholic desires, like the desire for alcohol, the addictions, is there something that you liken same-sex attractions to to make it like those things? I think alcoholism is recognized as something that's diagnosable, right?

A Right.

Q Same-sex attraction is not?

A That was a loose metaphor to help you understand the point --

Q Okay.

A -- that things don't always go away even if we want them to.

Q And so I think I understand it as far as a desired outcome that in you providing the therapy, it is a desired outcome that you are -- the therapy would -- you're not against the therapy resulting in that desired outcome of change in sexual orientation?

A Right. I'm hopeful the client --

MR. MIHET: Form.

THE WITNESS: The client is asking for that, so they're hoping to accomplish that goal, so that would be a -- that's a desired outcome for them. They have that.

And again, I want to be very clear: I know alcoholism is often seen as a disease. I am not calling homosexuality a disease. That was a very loose metaphor to help you understand. I'm not saying it's like alcoholism, something that is -- has the same implications that alcoholism does.

BY MS. FAHEY:

Q Is there something that you do liken homosexuality to?

MR. MIHET: Form.

THE WITNESS: No.

BY MS. FAHEY:

Q It's just a different thing that doesn't have a close metaphor?

MR. MIHET: Form.

THE WITNESS: Not off the top of my head. Maybe if I thought long and hard I might come up with something, but not off the top of my head.

BY MS. FAHEY:

Q I think I know the answer to this question based on things you've said, is it correct that it's

possible -- actually, I'm not sure.

A Okay.

Q I'll just ask the question. Is it possible to reduce or eliminate same-sex attractions without seeking to change sexual orientation?

A We know that sexuality is fluid. People do experience changes in their attractions without seeking to. We know that from the research. Is that your question?

Q What I'm wondering is are these two things so entwined that if you're seeking to eliminate or reduce sexual attraction, you're automatically seeking to change sexual orientation or can they be separated in concepts to whereas you could say "I would like to reduce or eliminate my attractions, but I'm not interested in changing my sexual orientation"? Can those be separated or are they entwined?

MR. MIHET: Form.

THE WITNESS: What is sexual orientation?

BY MS. FAHEY:

Q As we've been discussing it, we've been talking about attractions.

A Okay. So if you're -- maybe there's a different definition. That is my definition so it's -- I would say I have been talking about it as if it's a

synonymous concept.

Q Okay.

A Orientation is how you are oriented, but maybe you're thinking of it differently. If you are, let me know and I'll see if there's a -- you know, you're asking if you can separate two things, but I was thinking that we were defining them --

Q Yes. And so I do think I understand that you're saying if you're -- the attractions and the orientation are so entwined that if you're seeking to reduce or eliminate the attraction, there is a desired outcome on sexual orientation?

A What is sexual orientation?

Q So we've been talking about sexual orientation being the attractions that you have.

A Okay. So you asked the question. Is that what you meant by the word "orientation"? Did you mean "attraction"?

Q Yes.

A Okay.

Q Yes. And, truly, I do want to understand. In your practice it may be that in interacting with people who are talking to you about these issues there may be something where -- there maybe instances where people say, "I want to be gay. I want to be identified as gay.

I want to be perceived as gay, but I actually want to reduce or eliminate some of my attractions."

A So I would call that gender -- I would call that sexual identity.

Q Okay.

A So that's a different thing. So identity is how a person sees themselves. Orientation, how they're oriented, I think of that as how they're attracted, but perhaps it's used in a different way by others.

So if -- but what you just described to me I would not call just orientation, I would call that -- that's the person's self-concept or their identity.

Q Got it.

A Yeah.

Q Interrogatory number 7, I'll find the page for you so that we can get on the same page.

MR. MIHET: Literally.

THE WITNESS: Yeah.

BY MS. FAHEY:

Q So the question number 7 is on 6, but your response is on page 7.

MR. MIHET: Read the question.

THE WITNESS: Okay.

BY MS. FAHEY:

Q Now you state -- it's one of the small

paragraphs -- "Many of Hamilton's clients identify themselves as Christians and have sincerely held religious beliefs. The Bible stands as a source of truth. Various biblical truths are sometimes discussed with these Christian clients."

A Uh-huh.

Q Will you please share with me the biblical truths that you're referring to in your response to interrogatory number 7?

A Okay. Because I'm client-directed, I always ask them what their beliefs are, and so we discuss what they believe and how they see it and how that applies in their lives and how that applies to their -- the problems that they're experiencing. So you wanted to know what some of those beliefs are?

Q Not their beliefs, but what biblical truths are sometimes discussed with the Christian clients?

MR. MIHET: Form, asked and answered.

THE WITNESS: Well, so I used the word "truth" because you were asking that specifically in the question, what you communicated as, quote/unquote, truth, and so I was letting you know that my clients that are Christians will tell you that the Bible is the source of truth, and so what we discuss is various concepts that they find in the

Bible that they see as truth. Is that what you're asking?

BY MS. FAHEY:

Q Yes. And I'm wondering, if you could tell me more specifically, what are those concepts --

A Okay.

Q -- that you're referring to? Because you say various biblical truths.

A Uh-huh.

Q I'm trying to understand better the various biblical truths that are discussed.

A Okay. So with regard to this issue because your question is about clients that come in with this issue?

Q Yes.

A Because there are lots of biblical truths, like staying married and not getting divorced.

Q Yes.

A Okay. So with this, they would -- there's -- again, the clients' beliefs are that God created mankind, God created mankind as to -- within two different sexes, male and female; that he has an amazing design for our lives; that he wants us to be connected with him and in close relationship with him. They would say through Jesus; and that he's got an amazing plan for

our lives; and that when we walk in his plan, we are most fully alive and most fully at home with ourselves and most fully at peace.

And so they would say that if they're having attractions or feelings or behaviors that are outside of the way God has designed for their -- them to live their lives, that that puts them at conflict and not at peace, and so we talk about what those -- you know, how they see God's plan and how they see their experience not fitting with God's plan.

Q So I would like to find and show you a -- two different presentations that you provided to us, and I believe that each of these presentations contain what appear to be -- this says "Biblical view of gender and gender identity," and so I'm going to ask you whether those are some of the biblical truths that you discuss with minor clients, just to preface what I'm doing over here.

A Okay.

Q So the next number is 12. So we're going to mark Hamilton 026 through Hamilton 030 as Exhibit 12.

A You know, if I might say to you, you didn't ask me what I talk with minors about in this question. This was just in general.

Q Okay.

A So the answer to this was about in general what I talk with people about, but not specifically minors.

Q Do you talk to minors about biblical truths?

A It depends on what they believe. If they're not interested, no, I don't. I meet them where they're at.

Q Okay.

A Yeah.

(Thereupon, Defendants' Exhibit 12 was marked for identification.)

MS. FAHEY: And then Hamilton 021 through Hamilton 025 will be marked as Defendants' Exhibit 13.

(Thereupon, Defendants' Exhibit 13 was marked for identification.)

BY MS. FAHEY:

Q So what do you have in front of you right now?

A I have Number 13 and Number 12.

Q All right. So let's look -- we are looking at just the first page of both of these documents, Defendants' Exhibit 12 and Defendants' Exhibit 13. You can see one of the -- let me understand -- let me back up. Let's just take Exhibit 12.

Exhibit 12 appears to me to be handouts from a

PowerPoint slide. Is that true?

MR. MIHET: Form.

THE WITNESS: Yes.

BY MS. FAHEY:

Q And the first slide, the top left says "Understanding and Responding to Childhood Gender Identity Confusion and Homosexuality."

A Yes.

Q By Julie Hamilton, Ph.D, LMFT.

A Yes.

Q And underneath your name it says homosexuality101.com and drjuliehamilton.com?

A Yes.

Q Did you prepare the presentation that is Defendants' Exhibit 12?

A Yes.

Q Is that something that you have given as a talk before?

A Yes.

Q And have you had a chance to look at the pages of Defendants' Exhibit 12? Is this a true and accurate copy of your presentation?

A Yes.

Q Now let's go to Defendants' Exhibit 13. And Defendants' Exhibit 13, is this a printout of handouts

to a PowerPoint slide --

A Yes.

Q -- presentation? The top left square says "Childhood Gender Identity Confusion: Prevention and Early Intervention By Dr. Julie Harren Hamilton, www.homosexuality101.com"?

A Yes.

Q Is this a PowerPoint presentation that you prepared?

A Yes.

Q Have you had a chance to look at the pages and verify that this is a true and accurate copy of a PowerPoint presentation that you prepared?

A Yes.

Q Have you presented this presentation before?

A Yes.

Q Okay. Thank you.

So these are presentations that you've given. And on the first page of Defendants' Exhibit 12 and Defendants' Exhibit 13 there appears to be a slide that is titled "Biblical View of Gender and Gender Identity."

A Uh-huh.

Q That point 1 says that "Gender matters. In the biblical account of Creation, the only descriptors of humans are that we were made in God's image and that

we were made male and female," and I see that a verse is cited there.

A Right. Yes.

Q Is this a biblical truth that you would, with an interested minor, discuss on the topic of gender?

A Again, in therapy -- and you read in the code of ethics with the AACC. Even though I'm not a member of that organization, I've always practiced with the idea of expose, don't impose. So if they ask a question about that, I might answer that.

I do a lot of asking them questions, what do they believe, what do they see, and so we discuss truths, not me telling them "This is what the Bible says." It's not -- I don't approach therapy in that way or in an advice-giving "This is what you need to do with your life" type of way at all because I'm client-directed.

Q And so is this a truth that you would or have in the past discussed with an interested minor?

MR. MIHET: Objection. Form, asked and answered.

THE WITNESS: I don't -- I don't know if I've ever actually quoted that verse or they've ever quoted that verse. I don't -- I don't know.

BY MS. FAHEY:

Q Okay. Let's look at the point number two. It starts with "Marriage of the two genders." Do you see that?

A Uh-huh.

Q "Marriage of the two genders reflects the relationship of Christ and the Church. Marriage is a sacred symbol of the most important relationship of all: Our relationship with God through Jesus," and a verse is cited there from Ephesians 5:31-32.

A Uh-huh.

Q Is this something that you would regard as a biblical truth?

A That is a verse from the Bible, yes.

Q And is this a biblical truth that you have in the past or would if it was something that a child was interested in being exposed to or discussing with you, something that you would talk about in therapy?

A I don't ever remember --

MR. MIHET: Form.

THE WITNESS: -- sharing this verse with a child. Keep in mind these presentations were made for adults, not children.

BY MS. FAHEY:

Q Okay. So why don't we -- to save time, which Defendants' exhibit do you have in front of you? 13 or

12?

A 13.

Q Okay. So look on page 2, so that's Hamilton 22 --

A Uh-huh.

Q -- and you'll see 3, 4, and 5. Those appear to be points that have citations from the Bible.

A Uh-huh.

Q If you will review those, and let me know when you've had a chance to review them.

A Okay. Okay.

Q Are these points things that you would say fall under the category as biblical truth?

A The verses would be, yes.

Q Okay. Are these --

A My commentaries wouldn't be, but anything from the Bible -- a verse would be considered a biblical truth. So not the words that I have written, but the ones that are in quotes.

Q Understood.

A Okay.

Q Verses only?

A Yes.

Q Are these -- are these biblical truths things that you recall ever discussing with a minor?

A Okay. So let me -- maybe a better way of answering this would be rather than a yes or no. So, I don't recall sharing specific verses with minors. I don't have a recollection of any client sitting on the couch, telling them a verse, quoting them a verse, or opening the Bible and showing them a verse. I don't recall that. If I've ever done it, it might -- I mean I wouldn't be surprised if I ever said a verse because in speech that can happen, but I do not recall a specific situation of ever doing that.

Okay. However, it's important to note this: With Christian clients, there are truths that they hold about -- and it's summed up in each of those slides. These slides do sum up the beliefs that Christian clients hold, and your ordinance is in direct, I would say, disrespect and disregard for those Christian beliefs. And they're not just Christian beliefs. There are also Muslims and Orthodox Jews who believe similarly; but for the sake of this presentation and my clients, I will speak about Christians specifically.

Your ordinance tells us, as therapists, that we can only counsel in a way that is completely opposite of a Christian world view, which is disrespectful to our clients, at the very least. At the most, it's dismissive and discriminatory, honestly. And so I think

that has to be noted that these slides reflect the views of my clients, and your ordinance makes it impossible for those clients to get help from a professional in Palm Beach County. They can still go to their pastor, but their pastor doesn't have the training to help them deal with the psychological or emotional issues that may be going on in their lives.

And so I just want to state that, that, yes, this reflects a Christian world view. And I think -- I don't know the numbers exactly, but at least 50 percent of Americans believe this way, which is in the millions of people that believe this way. So there's going to be a lot of clients -- and even here in Palm Beach County, a high number of Christian clients that believe this way -- that are going to be left without services because freedom of speech no longer exists in a therapy office, and there's an ordinance in Palm Beach County that completely discriminates against Christianity and Christian beliefs.

So did that -- are there more specific questions you want to ask about this?

Q My specific question --

A Okay.

Q -- is what biblical truths do you discuss with -- and I understand you're not imposing, you're

exposing -- interested clients only, with minors? Interrogatory 7 advises me that there are some biblical truths that you may discuss with a client, and I respect the fact that you noted that that was not specific to minors, but this question is.

A Okay.

Q So specifically with minors, what are the biblical truths -- I had thought, but it sounds like you've been able to correct me, that points 1 and 2, you don't remember ever specifically discussing that with a minor.

A But I don't remember -- go ahead.

Q So you don't remember specifically discussing points 3, 4, or 5 with a minor either?

MR. MIHET: Form, asked and answered.

THE WITNESS: I don't remember specifically quoting Bible verses with a minor.

And I also want to add in number 7, where it said "various biblical truths are sometimes discussed," I wasn't saying I discussed them. Discussion takes place between two parties, so it could be the clients that are bringing up the biblical truths.

BY MS. FAHEY:

Q Okay.

A So I just want to make sure you understand that statement. Various truths, various biblical truths are often discussed does not mean me only, it means discussed between us, and quite often the client is sharing their biblical views. That's what that statement is saying. It's a discussion.

Q And do you recall a minor sharing with you biblical truths --

A Yes.

Q -- with respect to the issue of sexual orientation issues that they are coming to you with or gender identity issues that they're coming to you with?

A Yes, I definitely do.

Q And were those biblical truths, any of the five that we've been looking at, in your presentation?

A So the biblical -- I don't recall a client quoting a verse, but I recall clients saying "I believe this is wrong. I believe this isn't what God wants for me. I believe God has a different plan for me. I believe that he doesn't want me to pursue this relationship."

And my therapy, as I said before, client-directed, is about eliciting the client's beliefs and working from that frame of reference. Definitely clients bring up their beliefs. And I ask them

sometimes.

Q You just said something, "eliciting their beliefs." Interrogatory 7 --

A Uh-huh.

Q Interrogatory 7 you state that -- it's right under that paragraph with biblical truths. It's "The tools that Hamilton typically deploy are primarily ideas that she can elicit from the client."

A Uh-huh.

Q So what are you referring to when you say that? What ideas are you eliciting from the client?

A Well, because you had asked me what tools, so that was in answer to that.

Q Okay.

A So tools are getting -- finding out about the client resources. So it's things that the client believes are going to be helpful: What have you tried? What has worked for you in the past? What ideas do you have? What are your resources? What strengths do you have?

There's a lot of research that shows that if you use what clients bring to the table rather than introduce your own ideas or your own advice or suggestions, that if you elicit the client's ideas and their strengths and their resources, it's going to be a

lot more effective because it's something they already own and belongs to them instead of to you, so that's what I meant.

Q Can you give me an example of what you mean by a "client resource"? I don't know if you're talking about, like, tangible things or if you're talking about the client already has a faith system and so you're trying to elicit from that client their own faith system, to have that come to light. So --

A Okay.

Q -- for resources, if you could help me understand that.

A Yes. Resources are any tools or any -- I'm talking about internal resources. So faith might be one --

Q Okay.

A -- but it's not always a resource that the clients -- there are many clients that don't have a faith component.

So, in fact, I used to do a lot of presentations on this about being client-directed and how it is important to draw out the resources of the client. By "resources" we mean ideas that they have, so it's not just spiritually based. Faith is one resource that clients have, but they also have other -- they have

ideas. They have strengths. They have abilities.

Resources could be supportive friends, supportive family members. It's anything that helps the client in their life, either internal resources or it could be people. You know, a depressed client -- for a depressed client, one resource might be the people that are in their bridge group or -- you know what I mean? -- connecting with other human beings, so the people in their life might be a resource.

Q Okay. I think I now understand what you're saying --

A Okay.

Q -- as far as eliciting ideas from the client.

Interrogatory 7 also talks about -- it's in that same paragraph where we found the elicit ideas.

A Uh-huh.

Q The sentence starts, "In addition, Hamilton asks questions, listens, empathizes, seeks to expand options for the client, introduces possible explanations such as sharing theories of attachments and the role of parental nurture, and explores whether or not such theories fit for the client."

I am wondering if there are other theories other than early parental nurture and theories of attachment that may fit for a client. Are those the

only two, like, possible theories that might fit?

MR. MIHET: Form.

THE WITNESS: Are those the only two theories that might fit for a client?

BY MS. FAHEY:

Q That you may discuss with a client.

A No. Such as sharing theories.

Q Okay.

A No. I mean to explain what's happening in their lives? Theories that might explain their behavior is what I'm talking about here.

Q With respect to same-sex attractions and with respect to gender identity, are there any other theories other than early prenatal [sic] nurture and theories of attachment that may apply in those contexts?

A Absolutely. Yes.

Q What are the other theories?

A Okay. So when a client is experiencing same-sex attractions or gender identity confusion, there are a number of possible things that may have led that client to experiencing that and so it would be, of course, impossible for me to list them all. But keep in mind, too, I think it's important to note here that it seemed that -- it seems that as I talk to people about these ordinances with commissioners and those involved

with the passages of these ordinances, there seem to be this idea that they had -- whether they got it from the sponsors of the ban, I think that probably is the case, but wherever it came from, there seem to be these ideas that we are talking about a specific client, a gay or lesbian individual who is forced into therapy or even may come voluntarily but they are this way and they are either seeking or their parents are seeking to change them or for them to be changed.

Human behavior, emotions, and experiences are not like that. We're not in neat, little categories. There are -- I believe it's in the double digits of sexual identity labels that kids have for themselves or that are now used. So we get kids that come in saying they're pansexual, bisexual, asexual, transgender, agender. You know, all kinds of labels. So we're not talking about neat, little categories and we're certainly not talking about one neat, little category or two neat, little categories, and I think that's been the misunderstanding with the commissioners that I've talked to. People just don't quite understand we are seeing children that are coming in with all kinds of labels that they put on themselves. Some have persistence in early childhood and that is what I would think of as a more deeply felt experience, but there are others where

it's just kind of a passing trend. They've --

So your question was theories. Well, there's a lot of reasons why kids end up with labels on themselves. For some, that really have a deep sense of same-sex attraction or gender -- identifying with the opposite gender, these theories might fit and they might not, attachment and early parental nurture. But for a kid who never had that and all of the sudden --

I think there's something new called sudden onset gender dysphoria. It's just coming out of the blue. I think there was a recent article about that somewhere. And it's just this idea that they never had any gender dysphoria symptoms before and now they're a teenager and suddenly they're saying they're transgender. Well, for them these theories wouldn't fit because they didn't have that all along, but then perhaps -- and this article talked about for one kid they were -- you know, they were either seeing a lot of cultural influences, like having a coach that's transgender and suddenly that sounds like an appealing route to go, or maybe they've discovered pornography or maybe they've experienced abuse, a sexual experience in childhood or in adolescence that has created an appetite, a sexual appetite for them and now they're kind of craving what they first experienced because

their first sexual experience was something that, you know, was out of the ordinary and happened to them prematurely before adulthood and so --

Q What would I call that theory? The experience of trauma or pornography that then led to same-sex attractions, what's the theory -- what's that theory called?

A So, again, I think you're still thinking in terms of there are these kids that are gay and there are these kids that are straight and there are these crazy therapists that think sexual abuse caused these kids to be gay. It's not like that. There are kids that are not gay but they are sexually abused and now they are attracted to a member of the same-sex and they don't want that for themselves.

Q Is there a theory that --

A I don't know that there are names of theories like that.

Q Okay.

A It's just common sense.

Q And what I'm wondering -- I see you've identified two theories that may fit a child with same-sex attractions or gender identity.

A Uh-huh.

Q Are there any other common theories that we

would say could be an explanation for the type of children that you may see experiencing unwanted same-sex attractions or gender identity confusion?

MR. MIHET: Form.

THE WITNESS: According to the APA, they say we don't know what causes homosexual attractions. We believe it is both nature and nurture. And they say researchers have looked for a cause, they haven't found one, we believe it's nature and nurture. The nurture part includes a whole bunch of things that we couldn't possibly list.

There are resources that say there are higher levels of sexual abuse in early childhood that may contribute to same-sex attractions. There are -- certainly it's common sense that pornography exposure in early childhood, six, seven, eight years old, is going to create sexual appetites in children. So I don't know that there are named theories, but researches will tell you it's nature and nurture.

BY MS. FAHEY:

Q And what I'm trying to understand is what you may advise a client of "This theory fits for you." And so I'm understanding that you would advise some clients, if it's appropriate, that the attachment theory, that

that might fit for them to explain their experience, that's one. That you may also explain to a client that the early parental nurture theory, that that might fit for them to explain their experience.

It sounds like although there's no named theory, that you might also explain to a client, maybe their parents, that the trauma of sexual abuse may be a theory to explain what they experienced. So even though we don't have a name, it sounds like that would be something that you would explain to somebody.

A Okay.

Q Is that accurate?

A No.

Q Okay.

A Sorry. No. When I say "to see if it fits," whether or not theories fit with the client, they determine if it fits. I do not advise clients that "This is a theory that fits for you." It's "This is a possible theory. These are some things that could happen in a kid's life that could lead to A, B, or C. Does that fit for you?" But, typically, it is after they have told me their story that I connect the dots and say, "Do you think -- does that sound right?" I am always checking in this way: "Well, one possibility is you told me blank, you told me blank, you told me blank,

and that one -- and one possibility is that when this happens, then it could result in this and then it could result in this. What do you think about that?"

"Yes, that fits exactly." Or they'll say, "No, that doesn't fit for me."

"Okay. So maybe that's not the case for you. Tell me more." That's how it goes. I never advise that this fits for a client. They tell me if it fits or not.

Q Okay. So I misstated how you actually communicate the information.

A Okay.

Q So I apologize for that, for assuming how it's actually communicated. What I really am trying to figure out is more about the actual theories.

A Okay.

Q So however it comes up, however it is exchanged between you and the client -- we've got the attachment theory, early prenatal [sic] nurture. It sounds as though trauma is something that you may discuss with someone to explain "Does this fit for explaining your experience?" And it sounds as though pornography is another thing that you may discuss with the client -- maybe the minor, maybe the parent, I don't know -- as something that may explain their experience.

Is that two extra things that I just said --

trauma and pornography, things that you would say you may discuss depending on if it's appropriate -- a theory that could explain their experience?

A With the clarification that they may be the ones bringing that up.

Q Okay.

A They may say, "You know, I had this sexual experience with a friend and we were just friends and I wasn't gay, she did identify as a lesbian, but we got really close and then she started making out with me and now I really liked it and now I'm thinking I am bisexual." So she's -- the client is bringing that up.

And I may say, "Well, that makes sense because if you experience something and you found that pleasurable, you may desire that again and that may make you think you're bisexual because now you're desiring that again."

"Okay. That makes sense." I'm taking what they tell me and I'm validating their experience and their understanding of it and helping to clarify that. Does that make sense? Do you understand that?

Q I've got it.

A So, yes.

Q I've got you as far as how the theory comes up and how you might --

A Okay.

Q -- delicately introduce that as a topic of conversation. I'm not trying to find out more about that right now. I'm trying to figure out the world of theories that may come up.

A Okay.

Q However it is that you make them come up --

A So in the example that I just gave you, it's not a theory. It's not like --

Q Okay.

A -- there are these theories, "Okay. There are five theories on how a person becomes sexually attracted to the same sex." It's not like that.

It's like I was saying before, they're not in neat, little categories, and I think we see that from the research as well that it's -- it's very much ever changing and ever -- especially in adolescents but even in adulthood, and so I would not call them theories.

There are some theories that I share, but there are other -- maybe just explanations is a better word.

Q Okay.

A So, yes, the explanation that pornography wet a kid's appetite for the same sex could be an explanation. The explanation that a sexual encounter

created an appetite for the same sex could be an explanation. I would say it that way.

Q Okay.

A All right.

Q Are there any -- we've talked about this a lot, and I'm not trying to beat a dead horse, I just want to understand: Are there any other theories other than the ones you've specifically named here?

A There might be. I don't know.

MR. MIHET: And talked about today.

MS. FAHEY: She says those aren't theories. She said that the pornography explanation and the trauma explanation is not a theory, it's a possible explanation that may be discussed.

BY MS. FAHEY:

Q What I'm trying to understand is: Is there any other theories that have a name? Attachment theory you identify by name. Early parental nurture is something that you identify by name as a theory.

Are there any other theories that you have discussed with clients experiencing unwanted same-sex attractions or gender identity confusion that have a name and you could let me know the name of that theory?

A I don't know the names of any other theories.

Q Okay. Thank you. I just wanted to understand

if there were any others to know about.

A Okay.

MS. FAHEY: And we are beyond where we thought we were going to be breaking. I have no pending questions, so let's do our lunch break.

MR. MIHET: Okay. By my calculation, we are well over half of the allotted time for the deposition. I think the impressive level of detail, and I mean that in the nicest possible sense, that we're progressing with leads me to give you just a friendly reminder we do intend to limit today's questioning to the seven hours available under the rule.

So to the extent the city will have some questions, you guys will want to be cognizant of that and to abide by it.

MR. ABBOTT: About a quarter to two you figure?

MS. FAHEY: 1:45? Does that work for you guys?

MR. MIHET: Yeah, let's do an hour.

(Thereupon, a lunch break was taken from 12:48 p.m. to 1:48 p.m., and the testimony is continued in Volume II.)

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
CASE NO. 9:18-CV-80771-ROSENBERG/REINHART

ROBERT W. OTTO, PH.D., LMFT, and
JULIE H. HAMILTON, PH.D., LMFT,

Plaintiffs,

vs.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA,

Defendants.
_____/

VOLUME II

DEPOSITION OF JULIE H. HAMILTON, PH.D., LMFT

A WITNESS

TAKEN BY THE DEFENDANTS

DATE: AUGUST 30, 2018

TIME: 9:06 A.M. - 5:46 P.M.

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The deposition of JULIE H. HAMILTON, PH.D., LMFT, in the above-entitled and numbered cause was taken before me Angela Connolly, Registered Professional Reporter, taken at Palm Beach County Attorney's Office, 300 N. Dixie Highway, Suite 359, West Palm Beach, Palm Beach County, Florida, on the 30th day of August, 2018, pursuant to Notice in said cause for the taking of said deposition on behalf of the Defendants.

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Dr. Rachel Needle

- - - - - - - - - - - - - - - - -

(Thereupon, the testimony is continued.)

MS. FAHEY: Okay. For the record, Dr. Needle is no longer present. The county may have one of its employees, Dr. Shayna, S-H-A-Y-N-A, Ginsburg, G-I-N-S-B-U-R-G, join the county at the table of the deposition.

MR. GANNAM: Is that as a county representative or as an expert?

MS. FAHEY: County employee.

MR. GANNAM: Okay.

DIRECT EXAMINATION (cont.)

BY MS. FAHEY:

Q I am going to ask you, Dr. Hamilton, to turn with me in the Complaint to paragraph 150. So if I could ask you to check out paragraph 150.

A Uh-huh.
Q Paragraph 150 refers to a 12-year-old client, right?
A Uh-huh. Right.
Q And if you can turn to your interrogatories, I think you have it right in front of you with the number 7 facing -- yes. If you will turn to that answer to 22 where you give us the Doe numbers, I only see one of the Doe clients who is identified as a 12-year-old, and that's Doe 2. So I'm wondering, is it accurate that Doe 2 is the person you are referring to in paragraph 150?
A Yes.
Q So let's talk about Doe 2. When did your relationship with that person begin?
A I cannot say for sure.
Q Do you know about how long your relationship with Doe 2 lasted?
A A couple of years or more. I mean a couple being two, three.
Q Is Doe 2 a current client of yours?
A No.
Q Did your relationship with Doe 2 end or the file get closed within the last six months?
A Yes.
Q When did the relationship end or the file get

closed?

A Sometime within the last six months.

Q Why did --

A Spring probably.

Q Why did the relationship end or the file get closed?

A They were finished. They had accomplished what they came for.

Q Did Doe 2 have a diagnosis?

A No, not by me.

Q Were you aware of a diagnosis that any other practitioner had given Doe 2?

A I can't say with certainty.

Q Who set the therapeutic goal for Doe 2?

A The family, and they were differing goals.

Q What were the goals for Doe 2?

A The family probably initiated because of concern for same-sex attraction. The client -- the client identified -- didn't -- identified differently, not as same-sex attractions necessarily, but --

Okay. So, anyway, the client's goals were improving -- what was it? Improving home life or -- I can't say with certainty, but something along those lines a few years ago.

Q So I understand the parents had goals that

were related more specifically to same-sex attractions, but the child, at least at initiation of the visit --

A Yes.

Q -- did not share those goals?

A Right.

Q What goals did you work on with the child?

A The goals of the -- changing the family -- whatever the concerns were, the discontentedness with the family, we worked on that.

Q How did you do that?

A We talk about -- it's, again, conversation. I meet with the child. I meet with the parents. We look at what's not working, what is working. How do we increase what is working? How do we decrease what's not working? What does the child think they can do? What does the parent think they can do? How do they meet in the middle and make changes? Overall, I mean the more general goal is deeper, really, closer relationships and harmony.

Q Through pursuing those goals and discussing those goals, were the unwanted same-sex attractions of Doe 2 also addressed or is that something that was not addressed because the child didn't share the goal?

A What happens is -- again, back to what I was saying earlier today about it's not always so black and

white in our field. And so what happens is through the process of conversation, teenagers will often share with you all the stuff that's happening. And especially if they're not close with their parents, they are -- a lot of times teenagers love having a nonjudgmental listening ear, so they open up about everything, a lot of things. And so that's --

What I have found is that in the course of therapy we start out saying, "Okay. We're going to work on improving family relationships," but when I meet individually with the client, they talk about their friends and their -- so they start out talking about their family, but they talk about friends and activities and things they've done and things they haven't done, and so therapy kind of just proceeds with really building the therapeutic alliance or the relationship with the client, which in itself can be very therapeutic having a nonjudgmental listener that you can share with. And usually through the process of sharing, they're also processing their emotions as they share, just incidentally.

In fact, they have found out that sometimes research participants have a therapeutic effect because they're talking to a researcher who just wants to understand their experiences, and so just the act of

talking through with someone who's just listening and not trying to fix you can be very therapeutic. That's a little side note.

But anyway, that's how it usually transpires or goes with minor clients. And so it's just an interesting experience that through the dialogue they realize things, they make changes and so forth, and so that's kind of how this happened.

Q So specifically Doe 2, did Doe 2 have a -- did Doe 2 have same-sex attractions when Doe 2 began his or her care with you at the age of 12?

A Doe 2 identified as pansexual at the age of 12. If anyone at this table doesn't know what that means, I can now tell you. And, by the way, I think this is an important note: The things children are reading, hearing, watching online and experiencing and introduced to that in our generation we never --

I don't think any of us knew what pansexual was when we were 12 probably, but it's just another reason why kids need therapy to clear up their sexual identity confusion because they're identifying in all these different ways, and they're seeing pornography and other -- chat rooms. And, in fact, that was one of the things. There are some dangerous things that had been happening, and it just speaks to the need for freedom in

therapy that we need to be able to help these kids. They are confused more now than ever before in --

I mean they're hearing things and seeing things that you -- those of us at this table probably never would have dreamed of at 12 and 13 years old. So, again, it just speaks to the need of being able to clear up this confusion, and this ordinance prohibits us from doing that. It prohibits us from even --

If this ordinance had been in effect when this client came into therapy, I would not have been able to see this client. I would have had to tell the mother "No, I cannot help you because the county won't let me speak to your child about the confusion that this child is experiencing."

So, yes, that answers your question about how [redacted] was identified when [redacted] came in, pansexual.

Q Okay. And so for the record, Dr. Shayna Ginsburg, an employee of Palm Beach County, has entered the room and is now present for this deposition.

A Hi.

Q Could you give me a definition for pansexual?

A Uh-huh.

Q What is it?

A It's being sexually attracted to anyone. So bisexual -- being attracted to someone who is male,

female, agender, bisexual, transgender, anything, any type of label.

Q And so Doe 2, when he or she came to you at the age of 12 identified as pansexual, were you providing therapy to Doe 2 with the intent to assist Doe 2 in changing their sexual orientation to heterosexual?

MR. MIHET: Form.

THE WITNESS: That was not the client's goal. So that was the parents' goal, but the client's goal was different, and so I was accommodating the client's goal. And the parent -- like I had said before, as a family trying to agree, and so working on family closeness and improving relationships in the hopes that that would be a step towards the child being more anchored at home and less exposed to all the things that had been happening.

BY MS. FAHEY:

Q So is it correct for me to say that because it was not Doe 2's goal to change Doe 2's sexual orientation of pansexual to anything else, that was not something that you worked on with Doe 2?

A Right. To be very clear -- again, I don't know if I've actually said this or not, so I will say it just to be clear: If a client, if a minor client does not have the interest in changing attractions,

behaviors, or identity, there's not a thing I can do to help them change. You have to have a willing participant when it comes to this issue and most issues. And so in case I haven't said this already, there's -- there's never a time when I would be able to help a minor change in the area of attraction, behavior, or gender identity without their desire for that change to take place.

And I know I've said already that I'm a client-directed therapist, so obviously we need to have that be their goal anyway, but I just wanted to add the part that it would be impossible for change to occur without the client's participation or their desire for that to even happen.

Again, because therapy isn't something that we do to a client, like a dentist might give a filling to a client who has a cavity, it's a conversation. So we don't have the conversation if we can't -- if they're not a participant, we can't have a conversation and change is not going to occur on my -- it's not going to occur instigated by me.

Q Did Doe 2 identify as anything other than pansexual through the course of your therapeutic relationship with Doe 2?

A Yes.

Q Can you tell me what, if at all, change occurred?

A Yes.

Q In just their way of identifying, sexually identifying, or other changes? Why don't you tell me both.

A Okay. So changes occurred at the level of family relationships. Changes occurred in behavior that -- behaviors that were not related to this particular issue. Changes occurred in -- on the parents end as well.

And then as far as the identification, the client ended up identifying as -- I think it changed throughout probably different -- at different times, but I think the end identification was heterosexual.

Q Was Doe 2 happy or satisfied with the change that Doe 2 experienced throughout the course of Doe 2's therapeutic relationship with you?

A Doe 2 was very interested -- well, in the opposite sex by the end of the -- and that wasn't -- it was so -- again, the changes occurred not with my initiation, and the client appeared to be very happy with the changes.

Q But at no time was that a therapeutic goal for Doe 2 because Doe 2 did not embrace that therapeutic

goal of the parents?

MR. MIHET: Form.

THE WITNESS: Again, so we don't talk in -- I don't really talk in terms of "This is the goal. This is what we're working on." Certainly that was the parents' desire, so if you ask them what their goal was, that probably was still their goal whether with my help or not with my help. So a goal probably isn't the best way I would describe it, but at no time was I trying to get that client to change their attractions to heterosexual from pansexual; however, I was trying to help that client sort through all the thoughts and different feelings and emotions that they had in their head.

BY MS. FAHEY:

Q To what do you attribute Doe 2's change from originally pansexual to ultimately heterosexual throughout the course of Doe 2's relationship with you?

A I would say that in this case, this is a great example of a child who was very confused because of some very dangerous Internet interactions that were taking place and exposure to things that were far beyond the level of a 12 year-old to ever decipher or understand, and not to mention a history of abuse coming out of foster care and being adopted at an early age. So a lot

of things going on in that child's life, and I think that this is a perfect example of how your ordinance is extremely detrimental and dangerous for children because this child represents someone who is really not genuinely always feeling, you know, gay-identified or transgender-identified. None of that had even happened in their own identification of themselves until adolescence when they got into some very serious things.

And so this is representative -- this child is representative of many children that are out there now that access the Internet from their hands, their handheld devices. I mean children as young as first grade have phones and those phones can access the Internet, and there are predators. I mean there are things that, like I said, we as children never saw and never experienced, and these children --

I've heard one statistic that the average age of pornography exposure is between seven and nine. Let me tell you -- and we're not just talking about seeing adults having sex. We're talking about all kinds of stuff that, again, we even as adults probably haven't really even dreamed of. And so they're seeing these things and their little minds can't even begin to process what sex is, let alone what pornographic sex is. They're not meant to be able to process that in a stage

of development that they're at, and so we have a generation of kids that are more sexually confused than ever before in our history here in America. And you, the county or your clients, are taking away the freedom of those confused kids to get help to clear up their confusion, and what your clients are saying in their ordinance is we can help them by affirming their status even if their status was inflicted through cultural input such as pornography or other experiences, and we can help them become the opposite sex, but we cannot help them clear up their confusion if clearing up their confusion might mean returning from a gay-identified state or a transgendered state to a heterosexual state. Your ordinance states that we cannot do that.

And, in all honesty, 30 years from now we will all look back and say "What a devastating social experiment this was. What a devastating social experiment." And we will see the damaging repercussions that this has created in the lives of then adults, kids who will then be adults, and I think there will be so much regret by the people that have passed these ordinances. It's very sad, very scary. So this client Doe 2 exemplifies that. It's a perfect example.

In fact, when I was testifying for the Village of Wellington, this client wrote me a letter to bring to

the commissioners, and in that letter [redacted] said -- [redacted] described all [redacted] friends and all the friends who were identified -- asexual, agender, this and that, and just as confused as this client was, and saying "Please don't pass this ordinance because if you pass this, people like my friends won't be able to get help. They're using drugs. They're drinking. They're suicidal. They're depressed. They're cutting. And if you pass this ordinance here in Wellington, you're going to take away the chance for my friends to get help." And so I think this client is a perfect example, and [redacted] letter describing all of her friends are perfect examples of the confused children that are now being deprived of services.

Q Since you brought up the letter, I have a copy.

A Oh, good.

Q It was provided to the county at some point in your interactions with the county.

A Oh, good.

Q I don't know if this is the letter that you were talking about, so I'll have you let me know one way or another. So I am -- what number are we on?

MR. MIHET: 14.

THE COURT REPORTER: 14.

BY MS. FAHEY:

Q Okay. Defendants' Exhibit 14 for the record is a handwritten letter.

MR. MIHET: We are passed the age of consent, 13, 14.

MS. FAHEY: Got it. Harry's got jokes.

(Thereupon, Defendants' Exhibit 14 was marked for identification.)

BY MS. FAHEY:

Q Okay. So for the record this has the Bates labeled PBC 743 and PBC 744.

And, Dr. Hamilton, does this appear to be the letter that you were just referring to, that a client gave you a letter to assist you in your communication with I think you said Wellington at that time?

A Yes, it is.

Q Okay. Is this letter written by Doe 2?

A Yes, it is.

Q And you've let me know that you think that Doe 2 is a classic example of someone being confused, someone being exposed to things that are beyond their developmental level, and that being a contributing factor to their confusion.

What I'm wondering is to what do you contribute the change from pansexual identity to

heterosexual identity? Is there something that you would point to to say "I believe that this theory or this particular mode of therapy, this particular method of addressing confusion, was the thing that assisted this person in changing their identity from pansexual to heterosexual"?

A Yes. I would say it's -- what I was saying before about the process of talking, when you talk to a nonjudgmental listener, you actually start to hear yourself. And so therapy provides that context for people to -- to talk where they're not judged and they're not shamed and the therapist is empathizing with them and putting themselves in the person's shoes, and the profound effects of that on a client being -- for the client being heard and understood and valued are that the client then can stop and kind of listen to themselves.

Because when you're talking to someone who -- you know, whether it's parents or authority figures or whatever, where you think they're judging you or looking down on you or disagreeing with you, people tend to put up walls and get defensive and hold on to their position more tightly, but when they enter the therapy office and they're able to talk to a therapist and feel heard and understood and the therapist isn't trying to change them

and the therapist isn't shaming them and making them feel bad, finally they can let go of their defenses and they can listen to themselves. Is this what I want and is this who I really am? And so that's the first thing I would say is just the act of talking to a nonjudgmental listener.

You know, it's funny, in therapy you don't always know what makes the difference, so when I read this letter I didn't remember -- [redacted] said something in this letter the first time I read it back in Wellington, and --

MR. MIHET: Don't mind the note, keep going.

THE WITNESS: Okay. I want to make sure I'm understood and heard.

MR. MIHET: You're speaking to the record really so...

THE WITNESS: Okay. So -- it's funny. I can't talk when I'm not -- no, go ahead.

BY MS. FAHEY:

Q I'm here, sorry.

A No, that's okay. So you don't always know what makes a difference in a client's life. So I can tell you what I think made a difference, but sometimes clients will say something else made a difference in their lives.

So when I first got this letter a year -- I think it was a year and a half, it was when Wellington was going on -- 2017, I believe -- I read in here that something made a difference that I didn't even realize. And so to answer your question -- how did it happen? How did change happen? Is that what your question was?

Q My question is more specifically what do you attribute as being the cause or genesis of the change in this --

A Okay.

Q -- child? The child may say that something else was the change --

A Okay. Okay.

Q -- but you, as the licensed professional, what do you attribute change? And I have, as number one, the process of talking to a nonjudgmental listener.

A Yes.

Q So is there anything else that you attribute as the root, genesis cause, of this person's change?

MR. MIHET: Form.

THE WITNESS: And the -- you know, so included in the process of talking is the therapeutic relationship. There's power in feeling connected to another human being.

Clients often feel more connected to their

therapist at first than they do their family. The goal is to get them more connected to their family in the end, but -- so the therapeutic relationship is another thing. So I said the process of talking and therapeutic relationship, but then also in the process of talking is the client's ability to sort through their own emotions and discover what's really going on, so that might be a part of it too.

BY MS. FAHEY:

Q I understand that you said that the relationship with Doe 2 ended about the spring of this year.

A Right.

Q Did your relationship with Doe 2 change at all after the passage of Palm Beach County's ordinance?

A The changes that occurred in sexual identity had occurred before the passage of the ordinance, so my relationship did not have to change.

Q I'm going to refer you back to the Complaint, and I would like to ask you to look at paragraph 149.

A Okay.

Q And if you refer back to the list of Doe --

A Yes.

Q -- people, can you tell me which Doe number paragraph 149 corresponds to?

A Three.
Q Okay. So let's talk about Doe 3 then. When did your relationship with Doe 3 begin?
A I don't remember. I don't remember. Years ago.
Q You said many years ago?
A A couple I would say.
Q Is your relationship with Doe 3 ongoing?
A Yes.
Q Okay. Does Doe 3 have a diagnosis?
A No.
Q Are you aware of any diagnosis that any other practitioner has given Doe 3?
A No.
Q What are the therapeutic goals for Doe 3?
MR. MIHET: Form.
THE WITNESS: Again, we set -- we talked in the beginning about "Why are you here? How can I help you?" but it's not a concrete term. I don't continue to use the term "What are your goals now and how are those goals changing?"
So, initially, the client presented with having attractions and being in conflict about those attractions.
BY MS. FAHEY:

Q So when you said "client," are you referring to Doe 3?
A Yes.
Q And did the parent/legal guardian of Doe 3 also participate in communicating any goals in the initiation of the therapeutic relationship?
A Yes. The parent was concerned about the distress that the client was feeling about the attractions.
Q Was the goal from the outset to change sexual attractions?
MR. MIHET: Form.
THE WITNESS: So like I said this afternoon or earlier this morning, I always explain to clients that their attractions may or may not change, and so the goal is to understand possible contributing factors to explore the potential for change occurring, but I would not say the goal is to change the attractions because they may or may not change.
BY MS. FAHEY:
Q So for Doe 3, who presented to you with the fact that that individual had attractions and the parent perceived that the attractions were causing distress, what was the goal at the outset for the treatment of Doe

3?

A To -- let me think in the beginning. I don't remember off the top of my head. I could guess.

Q You don't have to guess.

MR. MIHET: Don't guess.

THE WITNESS: Okay. Okay. Thanks.

BY MS. FAHEY:

Q Did Doe 3 progress toward goals?

MR. MIHET: Form and foundation.

THE WITNESS: Okay. So with this client and as with most clients, many clients, the desires and aims of the client changed throughout -- so your question is did they progress towards goals? Their aim changed throughout the course of us working together.

BY MS. FAHEY:

Q During the course of working with Doe 3, did Doe 3 ever have the desire to maintain the same-sex attractions that they had?

A Yes.

Q And during the course of your treatment with Doe 3, did Doe 3 ever have the desire to reduce or eliminate the same-sex attractions that he or she had?

MR. MIHET: Form.

THE WITNESS: I believe, if I'm recalling

correctly, Doe 3 was talking more in terms of behaviors than attractions.

BY MS. FAHEY:

Q Okay. So when you say more toward behaviors, help me understand. Are you saying that Doe 3 was comfortable with the fact that they were attracted to a particular sex but not satisfied with the fact of their behavior?

A I think understanding that attractions may change as a result of dealing with other issues. So not aiming to change the attractions directly, but instead aiming to build a stronger sense of self to gain more confidence in gender identity.

So, in other words, in the identity of whether they were -- you know, to gain a sense of either masculinity or femininity depending on their gender, and then behave -- and then also behaviors, not -- I believe there were times when Doe 3 identified behaviors that were disturbing that this client wished to change.

Q Was Doe 3 sexually active?

A No.

Q What behaviors are you referring to?

A So I would rather that not go on public record because parents could also find information and --

So, in other words, minors share confidential

information about their behaviors and I don't share that with their parents, and so things that are said in the therapy office are very sacred and HIPAA protected and so if -- yeah. So let's talk generally, how about that?

So, in general, clients often share behaviors that are disturbing to them and some of the behaviors that a devout person of faith client would find disturbing would be if they were regularly viewing pornography or if they were dating and meeting people in chat rooms and meeting people on websites or, you know, dating people at school or church or any of those kinds of behaviors would be distressing to a client. Those would be the kinds of things that a client would seek to change if they were trying to change behaviors.

Q Okay. So Doe 3 was seeking to address behaviors that were not -- that were not satisfactory to Doe 3?

A Yes. And Doe 3 presented with very strong spiritual beliefs that were in conflict with behaviors.

Q What did you do to provide therapy to Doe 3 whose goal was to address behaviors that they were unsatisfied with?

A So as I was saying before, I'm a client-directed therapist. I sometimes use solution-focused approaches, and so I always -- with all

of my clients, when I'm trying to help them change their behaviors or things going on in their life, I always find out what works, what are their resources, what are their strengths, what are the ideas that they have, what are the times that they've been successful in overcoming their problem, what kinds of things do they think they've tried in the past that they might want to try again, that kind of -- that kind of approach in helping Doe 3 or any of my clients make changes in their lives. It's eliciting their resources and figuring out how we can apply those resources again to their current problem.

Q And so what -- you were eliciting resources from Doe 3's wheelhouse of available resources. What specifically are we talking about as far as providing therapy to Doe 3?

A Okay. So, for example, if a client is saying, "You know, I've been online viewing pornography every day this week, I really want to stop because every time I do it, I feel worse about myself. I don't feel better," then I might say to that client, "Well, what are some things that have helped you in the past when you've wanted to overcome this or a different problem?" And they might say, "Well, when I reach out to my friends and I go hang out with my friends instead of

staying home alone," or "Well, when I turn on" --

For these clients, many of them will talk about praise music, which is music that puts their mind on how great God is instead of just an idle mind that's looking for a sexual release, or they might say, "Well, when I exercise, I always feel good when I exercise," so things like that.

Q When that conversation happens and you ask them what helps you and they tell you -- let's say hypothetically the answer is "Exercise helps me not do what I don't want to do."

A Okay.

Q Do you then say to that person "Maybe try that" or do you just listen and not express any further thought or comment on what they give to you?

A Yes. I do more asking questions than telling them, but I would say, "Well, if that's something that you think might work, do you want to try that this week? Do you want to see" -- yeah. And there would be times too that I would say, "Oh, wow, that sounds like a great idea. That sounds like something that could work in this case. What do you think?"

Q Okay. Other than asking Doe 3, "What do you think you can do to stop the behavior that you don't want to engage in anymore?" and having that type of

conversation, were there any other therapeutic practices that you used with Doe 3 to assist Doe 3 in his or her goal of stopping behaviors that Doe 3 didn't want to do anymore?

A Okay. So just, again, therapeutic practices, so it's just conversation. So was there any other conversations that we had that were aimed to help [redacted] stop -- to help him or her to stop the behaviors? Probably. I mean eliciting resources, were there other resources that the client had or were there other things I did? Other types of questions maybe.

Q So I understand that one category of things that you might do is elicit resources --

A Okay.

Q -- that the minor client might have available to them --

A Yes.

Q -- to go ahead and use, and you might ask them "Is that something you want to try this week?"

A Right.

Q "That sounds like a good idea. What do you think?" So I got that.

A Okay.

Q Is there anything else that you might do in a conversation to assist that person in -- and speaking

specifically about Doe 3, whose goals sounded to be about behavior not about the attraction, that was Doe 3's goal --

MR. MIHET: Form.

BY MS. FAHEY:

Q -- anything else other than the resource eliciting conversation?

A The other thing --

MR. MIHET: Form -- sorry. Form, misstates prior testimony.

THE WITNESS: The other thing -- so the other thing that I had said earlier today is about a solution-focused approach where I look for what has worked when you -- you know, what has worked. Are there some times we can look at more closely when this wasn't happening? So what was going on during those times? What was that like? You know, what were you doing instead? That kind of questioning.

BY MS. FAHEY:

Q Did Doe 3 have success in Doe 3's goals?

A Because -- again, like I had said earlier today how it's -- therapy is more of an evolving conversation that takes place over the course of weeks and there have been -- throughout the course of therapy with this client and other clients, there have been

times where we are talking about something that improves and then -- you know, you're talking about a lot of different things, and so improvements in some areas and maybe not improvements in other areas, that kind of thing, or where they --

With teenagers, one of the consistent things is how much change occurs. So, you know, from week to week with a teenager it could be "Now I want to talk about my new relationship. You know, last week I was talking about how I want to avoid getting in a relationship. This week I want to tell you how excited I am that I'm in a relationship." You know what I mean? It's like -- and so you're kind of going through this process with them of helping them talk it out and figure it out and think it through because for some teenagers, they don't have other people that they're talking at a deeper level with.

So were goals met? Accomplishments were made and changes were made to the direction throughout the course of therapy.

Q And your therapy with Doe 3 is still ongoing?

A Yes.

Q Has your relationship with Doe 3 changed since the passage of the county's ordinance?

A Yes, it definitely has changed since the

county's ordinance. So what happened --

MR. MIHET: Let her ask the next question.

THE WITNESS: Oh.

BY MS. FAHEY:

Q How has it changed?

A Oh, okay, thank you. Yes, this has been very interesting to me living in America. I find myself unable to speak when the client -- on the weeks that the client is discussing wanting to either change behaviors, resist certain behaviors, or even hoping to change attractions by discussing deeper issues, I'm having to tiptoe and it's truly -- it would almost be laughable if it wasn't so tragic, but it's shocking. I find myself --

Well, when it first passed, I explained to the client "I can no longer help you if your goal is to change behaviors, attractions, gender expression, or gender identity. According to the county commissioners, I am no longer allowed to talk about those things with you."

So the client understood that and actually made the signal of flipping off the county with [redacted] finger, and I then went on to try to have therapeutic conversations each week and tiptoe around what I'm not allowed to talk about and think, "Okay. Can I say this

or will I get in trouble? If I say this, will the county think I'm trying to help this client change? Because I know I'm not allowed to help the client change, so maybe I should not talk about that, I should" -- it's unbelievable in America to be guarding my speech so carefully because what I say might be misconstrued as helping someone change, according to the county's definition, and could impose -- cost me a fine.

So, yes, it has changed my relationship because I'm hedging and carefully guarding every word that comes out of my mouth and saying to myself, "Oh, my gosh, the country where we have the most freedom of speech, we do not have freedom of speech. I cannot believe this." So, yes.

Q And can you tell me specifically things that -- I understand you're saying generally that you have experienced change. Specifically, are there things that you were unable to say to Doe 3 in the therapeutic relationship that you're saying you would have said if there was no ordinance?

MR. MIHET: Form, asked and answered.

THE WITNESS: Goodness, yes. The ordinance is vague. It just says we're not allowed to help clients if the goal is to change behaviors, attractions, gender expression, or gender identity.

So if I ask the client "How are you doing with not viewing pornography since that's what you want to" -- well, am I helping [redacted] change behaviors? Because the ordinance says I can't help [redacted] change behaviors, so I better not ask that question.

If I say -- if the client comes in saying I -- "I am, you know, newly committed to this process of wanting to change," I'm having to say, "Okay. Well, I can't talk to you about that, but we could talk about -- let's see. We could talk about, like, maybe helping you gain confidence in yourself." Like, what am I allowed to talk about? What am I not?

Yes, so there are questions that I think to myself "If I ask this question, I might get in trouble by the county," and those questions are -- I think I've given you enough examples or do you still want more examples?

BY MS. FAHEY:

Q It sounds like you've said you won't ask "How are you doing with not viewing pornography?"

A Uh-huh.

Q And I guess you're not asking them, based on your statement just now, "How are you doing with your desire to change?" You're not asking that question

anymore.

A Right.

Q Are there any things that you will not ask or will not say because of the county's ordinance, specifically with Doe 3?

A Everything that pertains to the topic of changing, yes.

Q I would like to look with you at Complaint's paragraph 151 and 152. It appeared to me as if both of those paragraphs referred to the same person. If not, let me know. But if you could look at those, I'd like to find out which Doe that refers to.

A Okay. They did not refer to the same person.

Q Okay.

A So, ironically, after the ordinance was passed, I had two separate phone calls from two separate parents of 12 year olds that were experiencing gender confusion. They are not in here because those clients cannot be my clients. And so here's another time where I literally have almost choked on my words as I've explained to these parents "I know we live in the United States, but believe it or not, the county commissioners have told me I'm not allowed to talk to your child about their gender confusion because -- if their goal is to change their gender confusion. So if your child is

saying 'I'm a girl, I think I'm a boy, or I'm a boy, I think I'm a girl,' I am not allowed to talk to them about that. The county commissioners have just passed an ordinance, I am so sorry." And I say this thinking to myself "What country are we living in? I can't even believe I'm having this conversation with these parents."

And so these two minors are minors that I was not allowed to work with. And let me add: They are both 12 years old. They are at a very important window of time in their lives when clearing up confusion would be very important.

We talked about earlier how many children, young children, will outgrow the transgender confusion. When it's still happening at the age of 12 or if it was a sudden onset at the age of 12, it needs to be addressed before time goes on. So I will tell you these two I am most concerned about because the county has stopped me from helping them. They are now going on in their confusion and they're getting older; and if this ordinance is not lifted, those children will suffer detrimental results.

And I know that I'm sounding emotional because I feel emotional because damage is being done as we sit here debating this. I would like to pick up the phone

and tell those parents "Come on in. You can come Tuesday and I can start working with your confused child," but I can't. So please consider this as you're working through this whole process of defending your clients who have passed an unlawful, unconstitutional ordinance. I'm done.

Q So paragraph 151 and 152 refer to two different children?

A Yes.

Q They're both 12 years old and neither of those individuals have been, in the past or are presently, your client; is that correct?

A Okay. So, again, I have families as clients.

Q Okay.

A For each of these, I did invite the parents to come in. I met with the parents. The minor client I am not permitted to work with. So I met with the parents, but I cannot go any further.

So I am not currently seeing either of these two families, parents or minors from these two, number 151 and number 152, but in both number 151 and 152 I sat down with both sets of parents.

Q Okay. So you sat down with them in the context of they were your clients, the parents?

A The family becomes the client.

Q Okay.
A And so the parents --
MR. MIHET: I'm sorry. Can we go off the record for just one second?
MS. FAHEY: Sure.
(Thereupon, a brief discussion was had off of the record.)
MR. MIHET: Let's go back on the record so we can clear up the confusion.
THE WITNESS: Okay. So I would like to apologize because I did jump to 157 because those are the ones that are burdening me the most. I just -- every day goes by that they don't get help, so I jumped ahead in my thinking because these are on my mind, pressing on my mind, that these kids are unhelped because of this ordinance. So I apologize for jumping ahead to the one that's most on my mind.
MR. MIHET: So just so we clear up the record, the two examples that you were talking about, which paragraphs in the Complaint reference those clients?
THE WITNESS: Number 157. Number 158.
MR. MIHET: Okay.
BY MS. FAHEY:

Q Okay.
A Okay.
Q So if you could look back to 151 and 152, I'm wondering if those two paragraphs refer to the same person or if 151 refers to one and 152 refers to another.
A Okay. Number 151 and number 152 are connected. So the client number 150 wrote a letter describing the people in 151. So the minor client of 151 is the same minor client as 150, but the description is about that -- the client's friends --
Q Okay.
A -- in 151.
Q So did you see, as your patient -- I understand that paragraph 150 refers to Doe 2. Did you see the individuals who were referred to in 151 or 152?
MR. MIHET: Form. Which individuals? There are several.
BY MS. FAHEY:
Q In 151 and 152, does there appear in those paragraphs a reference to any of your other clients? I know we've discussed Doe 2.
A Okay.
Q So what I'm trying to do is to see if I can connect the Doe numbers to the other information you've

provided me --

A Okay.

Q -- to see -- are there any other clients in 151 and 152?

A Okay. 152 is Doe -- is the same as number 150. They are the same client, talking about two different time periods in that client's history with me. When they first started it was -- so 150 and 152 are the same client.

Q Got it.

A 151 is referring to the kids listed in that -- the kids described in that letter, and I did not see any of them. They were not my clients, but they represent -- as I said earlier, they represent the types of children that are out there that are confused that are being declined services.

Q And the letter you just were referring to, we're referring to Defendants' Exhibit 14 for the record.

Okay. And so it sounds like we have identified, by Doe number, all of the clients that are -- would be in paragraphs 150 through 152, and the only client discussed in those paragraphs is Doe 2. Certainly some of the people that Doe 2 has informed you about also appear referenced in there, but no other

clients in 150 to 152 other than Doe 2?

A Yes.

Q Got it. All right. Let's move on then to Doe 4. Doe 4 you told us is an individual who was 15 years old at the time they began treatment with you -- and I'm referring to your answers to interrogatories, that list that you have in front of you -- 15 years old at the onset of treatment who presented with unwanted same-sex attractions or behaviors.

Do you recall whether, in Doe 4's situation, it was attractions or behaviors?

A Okay. So this might save you time, I'm just going to be honest with you, other than Doe 5 that we already talked about, all the remaining Does, 4 through 11, with the exception of 5, I honestly do not remember who they are. I went -- I pulled out all this data out of my files to submit to you, but I didn't know you wanted details on them.

I don't even remember -- I don't know if I was supposed to remember who they are, but it was me gathering tons of data for you, so I don't know who they are.

Q Okay.

A Okay.

MR. MIHET: That just shortened the deposition

considerably.

THE WITNESS: It's over the last nine years. If I saw them one time, I would have no remembrance.

BY MS. FAHEY:

Q So go with me real quickly --

A Okay.

Q -- Doe 4, is that file still open for you?

A No.

Q Doe 6, is that file still open for you?

A No.

Q Doe 7?

A No.

Q Doe 8, is the file still open?

A No.

Q Doe 9, is the file still open?

A No.

Q Doe 10, is the file still open?

A No.

Q Doe 11, is the file still open?

A No.

Q So for all these individual that we have not discussed in detail, do you recall any of their therapeutic goals?

A I do not.

Q Do you recall whether any of them experienced a change in their unwanted same-sex attraction or behaviors?

A I don't. I'm so sorry.

Q You don't have to apologize.

A Okay.

Q This is not meant to be a memory test. You know --

A Thank you.

Q -- or you don't know. And if you don't know, don't remember, that's what it is.

So you don't recall their goals. You don't recall whether they experienced a change. All of these files are closed. That's all true?

A Yes.

Q And when I say "all," 4 and then 6 through 11.

A 4 is closed and 6 -- yes.

Q 6 through 11.

A Well, and 5 is closed also.

Q 5 is closed also?

A Years ago.

Q So the only Does on this list who are still clients are 1, 2, and 3?

A Yes. And then others that would like to be clients.

Q And do I remember correctly that Doe 2's therapeutic relationship with you closed spring of this year?

A Yes.

Q Okay.

A Yes. Thank you.

Q So it's Doe 1 and Doe 3 --

A Are open.

Q -- are open?

A But Doe 1 could close. I think I mentioned earlier I haven't seen them in a while, so you never know.

Q Did the files that are closed, that we haven't spoken about in detail, that's Doe 4 and then 6 through 11, were those files closed before the county passed its ordinance in December of 2017?

A Were they closed before that? Yes.

MR. MIHET: Progress.

BY MS. FAHEY:

Q Is there anything that you do remember about these individuals that you've let me know generally don't remember the goals, don't remember the outcome? Is there anything that you do remember about any of these people: Doe 4, Doe 6, Doe 7, Doe 8, Doe 9, Doe 10, and Doe 11?

A I don't even remember who they were at this point. I'd have to go back through my files.

Q Okay. Then I am going to move on to a new area of inquiry with you --

A Okay.

Q -- and that is religion. One of the claims that you have brought is that the ordinances in Palm Beach County and in the City of Boca Raton, you have claimed that they violate your ability to freely exercise your religion.

A Okay.

Q Right?

A Yes.

Q And your religion I believe you have stated is Christianity?

A Yes.

Q And you have said you attend Truth Point Church?

A Yes.

Q Are you also a member there?

A No.

Q Are you a member in any church?

A No.

Q Do you identify with any specific Christian denomination?

A Non -- no. Nondenominational.
Q Does your religion require that you conduct therapeutic practices that seek to change a minor's sexual orientation?
MR. MIHET: Form, assumes facts not in evidence.
THE WITNESS: I would say that part of being a Christian is caring about the needs of others, being compassionate, reaching out to meet a need if you can possibly meet a need. And so the way the county ordinance prohibits me is from preventing me from being able to meet the needs of my clients that are coming in, which I see to be really, in some cases as I've kind of mentioned already, very serious needs. So that would -- that's --
And then the other thing about the ordinance, and I think I did say this already, is that it is written in a way that would be discriminatory against religious beliefs.
BY MS. FAHEY:
Q And so I'm asking specifically --
A Me.
Q -- if your religion specifically requires people who subscribe to your beliefs, whether your religion requires people to engage in therapeutic

practices to seek to change a minor's sexual orientation. Is that a specific requirement of your religion?

MR. MIHET: Form.

THE WITNESS: Of my --

MR. MIHET: I'm sorry. Form, asked and answered.

THE WITNESS: Of my role, am I required to help people with that issue?

BY MS. FAHEY:

Q Does your religion --

A Yeah. No, I'm not required to be a therapist, but as a therapist, I certainly -- it would be a violation of my conscience to administer therapy in the way that your ordinance says, which is that I can either affirm their homosexual attractions when they don't want those attractions, to do that would be a violation of my religious beliefs, and your ordinance also says that I can support them in a gender transition, which there's no evidence to show that that's a safe route for children. In fact, the law shows it's a dangerous route.

So if I went along with your ordinance and implemented therapy, which I'm not required to be a therapist according to Christianity; but because I am a

therapist, if I applied the ordinance in my therapy practice, I would be violating my religious convictions. So I can either not provide therapy, I can choose not to provide therapy, but as long as I am a therapist and that is my livelihood, that is my occupation that I went to school for, and I have people coming in with this need, I can't help them the way your ordinance suggests I should help them. So I could turn them away. I could turn them away.

BY MS. FAHEY:

Q Does your religion require that you conduct therapeutic practices that seek to change a minor's gender identity?

MR. MIHET: Form, asked and answered.

BY MS. FAHEY:

Q Sorry. We were just talking specifically about sexual orientation. The question has now changed to gender identity.

A Okay. I didn't realize that. And again, not that it's a practice that I implement on people like filling a tooth, it is a conversation that I have. Therapy is a conversation. And so kind of -- I guess I already answered that not knowing I was -- I should have broken it down into two separate answers, but it would violate my conscience to apply this ordinance in my

practice.

This ordinance says it is okay for me to support a child in a gender transition. And the children that aren't asking for a gender transition and their parents aren't wanting that for them either, that are asking for help, I'm not allowed to help. To do what your ordinance is suggesting I do, which is support them in a transgender transition, would absolutely be a violation of my religious convictions, and safety really, to be honest with you. There's no research that would back that up.

Q Does your religion require anything specifically -- with respect to people who believe what you believe, does your religion require you to do anything specifically with respect to a minor's sexual orientation or a gender identity?

MR. MIHET: Form, asked and answered.

THE WITNESS: I am not required to do anything, but I'm a therapist and I do offer services to people that are hurting and needing help.

So as a therapist -- I wasn't -- there's nowhere in the Bible that said I had to become a therapist. I wasn't required to be a therapist, but I am a therapist. And I'm not required to --

no, but I am --

I mean, yeah, I feel like I need to help the people that are coming to my office, and I'm restrained from doing that.

BY MS. FAHEY:

Q Now you have shared with me, in the context of our earlier conversations in the deposition, about what a client may believe as religious truths, and so we are in a section where I am asking you about your religion.

A Okay.

Q And so do you believe that God made male and female for a purpose?

A Yes, I do.

Q Do you believe that identifying as a gender that differs from one's anatomical sex is a sin?

A What is a sin? What's a sin mean?

Q What would you say a sin is?

A Do you have a definition of it?

Q Do you have a definition of it?

A I'll give in. Well, some would say that sin is -- some would say the exact definition is missing the mark. So, in other words, if God has a standard and you miss that standard, that is sin.

And so some would say that there are lots of areas where God has set up an amazingly, wonderfully

standard, and we do fall short of that standard and we miss the mark, and we are all, at times, guilty of sinning. And so if that's how we're defining sin, I would say that there are a lot of behaviors that people exhibit that would fall into that category. And I would say that probably -- I wish I had percentages, but half of Americans would agree that -- so for sex outside of marriage is not a part of God's plan or intent, but -- so I think because a lot of people would agree with that, that tells me that there are a lot of clients that are going to come in distressed over attractions that lead them to want to do things that are outside of God's plan, number one.

And, number two, I want to make it clear that my personal beliefs do not get imposed on the client. So as you're talking about my personal beliefs, I want to be very clear on the record to say that what I believe about whether divorce is a sin or whether homosexuality is a sin or anything else, I do not push on to minor clients. I do not have conversations with minor clients telling them what I believe. My -- like I said earlier today, my conversations are about asking the minor clients what they believe.

So these questions that I'm answering, while I'm -- you're wanting to know my personal beliefs, it

has to be perfectly clear that they do not enter into the therapy session unless the client is coming to me because I share the beliefs and then you're talking about the client's beliefs.

Q And so we are in that section where I'm specifically --

A Okay.

Q -- talking about you and the beliefs you hold.

A Yes.

Q We have moved after -- beyond the section where I've asked -- where I'm asking about the therapy --

A Yes.

Q -- at this point right now.

A Yes.

Q So do you believe that identifying as a gender that differs from one's anatomical sex misses the mark of God's plan?

A I'm sorry, say that again. Identifying as --

Q A gender other than what your anatomical sex is misses the mark for God's plan.

A Okay.

Q Which is kind of like a supplemental definition you gave me for sin.

A Okay. I would say perceptions and feelings

are not sin. Behaviors would be sin.

Q Do you believe that God designed humans to be heterosexual?

A I believe that God designed men and women to go together both anatomically. I mean common sense shows that, and you see that in the animal kingdom, so, however, my personal beliefs do not enter into the therapy session. Okay.

Q I understand that.

A Okay.

Q And this is still the part I'm asking you about your beliefs.

A Okay. Yes. Yes.

Q Do you believe that God's design for humans is that humans are to be heterosexual?

A I think I answered that question. Did I? I think I answered it.

Q Okay. Yes.

A To be heterosexual -- that men and women pair up, is that what you mean by heterosexual? Because not everyone is attracted sexually to the opposite sex. So I would say it's not God's design that every single person has to have sexual feelings. There are some people who are single and they don't have sexual feelings. Maybe they would call themselves asexual or

something. I wouldn't say --

Q Is homosexuality within God's design for human beings?

A Did God design men to be with men and women to be with women? My personal belief would be no, and there's a lot of things that God didn't design and I -- and yet he loves us.

Q Do you believe that changing same-sex attractions is possible apart from God?

A Yes.

Q Do you believe that changing gender confusion is possible apart from God?

A Yes. Let me back up. Personally I would say -- you know, there's an old scripture that says "in him we live and move and have our being," so I would say every breath we have comes from God, so ultimately I give God credit for the fact that, you know, we're all sitting here and able to continue to breathe without, you know, having an embolism or something, you know what I mean? He keeps our hearts beating and keeps us --

So I would say that, so ultimately I give God credit for everything good and everything that happens in the world, but if you're saying can people without God pursue change in their lives and experience change? Yes, there are people that don't seek God's help

actively or outwardly that change in areas that they desire to change sometimes, but ultimately is there -- is God really behind it all? Well, I think God is behind a lot of things. Does that make sense?

Q That's what I'm wondering. I'm wondering if you believe that it's God that effects the change in a person.

MR. MIHET: Form, asked and answered.

THE WITNESS: I don't know. I'd have to think about that.

BY MS. FAHEY:

Q Is change possible without talk therapy?

A Yes.

Q Do you believe that change is impossible without the therapy that you provide?

MR. MIHET: Form, asked and answered.

THE WITNESS: I do not believe that it is impossible. I believe that when I say "No, I can't see a client," their opportunities for change are greatly decreased.

BY MS. FAHEY:

Q Can a minor achieve the same type of same-sex attraction change through religious mediation alone?

A Can a client -- say that again, I'm sorry.

Q So can a minor achieve the same type of change

with respect to their same-sex attractions -- if they don't seek licensed practitioner therapy, but they do seek religious mediation from a religious leader or religious person without a license, can they experience the same type of change if they go the religious route with no license on the side?

A I don't know.

MR. MIHET: Form.

THE WITNESS: I think it would depend on who they see. I don't know of any lay people in this county that I would refer to if I have clients that I'm turning away. I've racked my brain to think what can I do for these kids that are getting older without help, and I honestly don't have a lay person that I would refer them to. I don't know a pastor that's trained in that issue that I could refer them to.

So, yes, it's possible for somebody to get help, but in this county I don't know who that would be that they would get help from.

BY MS. FAHEY:

Q Is there a specific type of psychotherapy that has empirical support for successfully effecting a change on a minor's sexual orientation?

MR. MIHET: Form.

THE WITNESS: There has not been much research on minors for any issue, so you will not find research that I know of. I'm not aware of much research that's been done on minors with depression, minors with anxiety. A lot of research is done on adults for, you know, obvious reasons. You don't want to be experimenting on a minor.

So as far as this issue and research that's been conducted on minors, I'm not aware of any research that has shown therapy to be harmful with minors because I don't think there are many, if any, studies that have been done on minors that show therapy to be harmful, helpful, or -- harmful, helpful, or -- or any other type of research on this issue with minors, other than the research that shows the detriments of hormone therapy for minors with gender confusion. There is research on that.

BY MS. FAHEY:

Q So let's go to adults. I asked you about minors.

A Yes.

Q Are you aware of any type of therapy that has empirical support for successfully changing an adult's sexual orientation?

A Yes. A new article just came out last month.
Q And what type of therapy did that article study?
A I'd have to look at the article. Do you want me to take time to look at it? There are lots of research studies that have shown talk therapy to be effective talk therapy.
Q So talk therapy is the type of therapy that you are saying that empirical study was about?
A This most recent one I would have to review it again, but in past years there have been studies that have shown talk therapy to be effective with people looking for help with homosexual attractions, behaviors, or gender identity. Or, I'm sorry, let me limit that to homosexual attractions and behaviors --
Q Okay.
A -- and gender identity.
Q Now it's going to be the same questions but we're going to talk about gender identity.
A Okay.
Q What type of therapy has empirical -- and it might be the same exact answer, "None, not enough research about children." So what type of therapy has empirical support for successfully changing a minor's gender identity?

A Okay. Zucker, who you referred to earlier, has done a lot of research on gender identity with children because he worked with them for years and had very high success rates. So his articles -- he published maybe hundreds of articles and books on the work that he did in Canada with gender identity for years.

Q And is there a specific type of therapy that Zucker has studied to show this is the type of therapy that should be employed for this type of success?

A I'm not sure.

Q And what about adults, we'll change that to adults. What type of therapy has empirical support for successfully changing an adult's gender identity?

A What type of therapy -- oh, gender identity. I'm not sure about gender identity for adults in the same way that -- with homosexual attractions and adults. I'm not familiar with that body of literature.

MS. FAHEY: Can we go off the record just a second?

MR. MIHET: Yes.

(Thereupon, a brief discussion was had off of the record, and a short break was taken from 3:05 p.m. to 3:12 p.m.)

BY MS. FAHEY:

Q So I have heard you say that you cannot change someone's sexual orientation or gender identity. Is that accurate?

A Just like I cannot take away someone's depression or anxiety or obsessive compulsive disorder.

Q And so I heard you say that there is research that talk therapy can change a person's sexual orientation.

A Okay. Thank you for asking for clarification there. That is definitely not what I meant.

So there is research that shows talk therapy is helpful in reducing attractions, but that does not -- it doesn't mean something was done to a client that changed their sexual orientation, but researchers have found that clients have experienced a reduction in same-sex attractions through the process of therapy, of entering therapy with a therapist.

Q Is there -- I have heard an analogy that sexual orientation is like the weather. You can watch it change, but you can't make it change. I've heard that analogy before.

A Okay.

Q Is that analogy something that comports with your understanding of how sexual orientation may change? You can watch it change, but you can't make it change?

MR. MIHET: Form.

THE WITNESS: No.

BY MS. FAHEY:

Q Okay. Why not?

A There are things that we do in therapy, such as conversations that we have about various things depending on the person, and those conversations can lead to change. Whereas if you're watching the weather, you can't really have conversations that might result in a change in the weather, so that would be different.

Q Other than these conversations that might lead to change, is there anything else that you're aware of that also might lead to sexual orientation change?

A Well, so we're talking about therapy. All therapy is conversation, so there are many different types of conversations that can be had in a therapy room.

So if you're saying is there anything else in therapy that can lead to change? I would say all therapy is conversation. If you're saying is there anything outside of therapy that can lead to change? There are other -- there are some studies that show clients going into ministries. You know, that can produce change.

Unfortunately, the problem is in this

county -- well, there are no ministries for minors. I don't know that there ever have been. They're usually for adults. And in this county, there's not a ministry support that's offered for even adults in this county, so we don't have those options in any of -- in all of Southeast Florida I don't know of any ministries, but there is research that shows ministries can be helpful, lay-led ministries. There's one really good study that showed significant change because of ministries.

Q And are you referring to the longitudinal study of adults who were involved with the Exodus Ministries?

A Yes, I am.

Q Are there any other studies that you're referring to when you made that statement?

A There are some -- let me think. There have been some other reports that have been published, that I can't think of them off the top of my head, about people that have gone through various ministries, uh-huh.

Q Okay. So I've got therapy. I've got religious ministries. Is there anything else that you would add to the list of things that may effect a change in sexual orientation?

A I would say there are a lot of things. I guess one way that I always sum it up is there are many

pathways into and out of homosexuality, so I probably couldn't name all the different ways people get into it or out of it.

Q How about primary ways of the out of it part?

A So if we haven't already included support groups, sometimes that's a part of ministry.

Q Okay.

A Other ways that -- well, spontaneous change, we probably already covered that. That would be more like your weather analogy, I guess, that you're talking about intentional change outside of therapy.

I mean there are -- I think there are things that people do: Maybe they read books, they attend conferences, they -- and sometimes therapy is an aid in helping them discover what some of those things might -- what might be most helpful for them because, like I said before, in therapy, you're discovering what works for people. You know, is this person a reader? Do they benefit from reading books? Okay. Well, maybe there are some books they could read.

So therapy kind of helps connect people with other avenues. So there are a lot of avenues that people can take to experience change, but I would say therapy is a really, really important one because usually it's therapists that are trained to understand

how to have conversations that are effective and healing and meaningful and so forth.

Q Are you aware whether or not the AAMFT has a position with respect to sexual orientation change efforts?

A I have not seen that in their ethical codes.

Q Are you aware of any position of the AAMFT with respect to sexual orientation change efforts not contained in their ethical codes?

A I'm not sure, but I think it's maybe important to point out at this point that it is ironic that the professional associations have not included this in their ethical codes, but the county commissioners who don't work in our field or really have anything to do with the laws and rules or the ethics of our clinical practice do, and I think there --

I think that's a point that should be noted is that the APA, when they put together their task force and they looked at the research and they developed a resolution, they didn't have the ability, the foundation, the research, scientific foundation to be able to put it in their ethical codes and even recommend that lawmakers make it illegal. And so if the APA hasn't done that after reviewing the literature for two years, they looked at all the literature, they made a

resolution, and they've made positions statement -- there are a lot of position statements, but it hasn't been deemed -- it has not been, you know, taken to the level that I'm aware of. Maybe that will happen at some point, but for county commissioners to get involved -- and I don't know if you were going to say something. It sounded like you were going to say something.

MR. MIHET: She can't answer.

THE WITNESS: Okay. Okay.

BY MS. FAHEY:

Q Just me and you.

A Okay. I heard comments or something down there.

So anyway, I -- yeah, I think that's just an interesting point that should probably go on the record is that the county commissioners have sort of stepped in where I don't think the professional associations have yet, to my knowledge.

Q So it sounds like the answer to "Are you aware of any position statement by AAMFT on the subject of sexual orientation change efforts?" it sounds like the answer to that is you're not aware?

A I don't know.

Q Okay.

A No. There may be a statement that they made.

I'm not an active member of that association.
Q You're not an active member --
A No.
Q -- of the AMFT?
A Right.
Q But you subscribe to their code of ethics?
A Yes.
Q Are you aware of ways to engage in therapy with a person who has unwanted same-sex attractions without trying to change their same-sex attractions?
A I'm sorry, could you say that again?
Q Yeah. Are you aware of ways to engage in therapy with a -- and we'll say minors -- with a minor who has unwanted same-sex attractions without trying to change that minor's same-sex attractions?
MR. MIHET: Form.
THE WITNESS: Am I aware of ways to engage with a minor to help them change without helping -- am I aware of ways to engage with a minor --
BY MS. FAHEY:
Q Who has unwanted same-sex attractions --
A Okay.
Q -- and may want assistance dealing with their distress or depression or some other specific issue. Are you aware of ways to work with them in therapy

without trying to change their same-sex attractions?

A I think -- yeah. I mean, I think that's always -- what I've been talking about today most of the day when we were talking about my practice. So there are -- wait, wait, wait. Minors that want help changing or don't want help?

Q Either way.

A Okay. So what I was saying to you earlier today is about, you know, there are minors that come in not asking for help, but the process of therapy, working with them and just talking to them and listening mostly to them, they listen to themselves -- remember when I was telling you all about how, when you are talking to a nonjudgmental listener, you often hear yourself and sort through things and come to new conclusions? So is that what you mean?

Q And so in that situation, it sounds like the therapy you would be providing would not be seeking to change their same-sex attractions. Change may happen, but the therapy is not aimed at change. You're still giving therapy to a person who has same-sex attractions and not giving therapy that's trying to change the same-sex attractions.

A Okay. However, under this ordinance, I would not be at liberty to do what I'm talking about because I

would have to think constantly -- like I told you with the client where I had to change my position, my way of interacting after the ordinance was passed. I would have to think of every question I ask, "What if this could be misconstrued as me trying to change them or me trying to help them change?" I would -- it would be impossible to have free-flowing conversations that are genuine and authentic under this ordinance.

So, yes, minors can change when they're not seeking change just through the process of therapy, but that's therapy that's unhindered and has no speech restrictions. Under this ordinance I have speech restrictions. There are sentences I can't say and questions I can't ask, so it is impossible for me to proceed in a genuine conversation of listening and talking with someone when I'm constantly questioning myself of whether I'm allowed to say this or not.

So, no, I don't think therapy would be as effective under this ordinance even if I was just offering -- even if I was trying to avoid the goal of helping that client change in any of their behaviors or anything like that. Therapy cannot be as effective because you're constantly second-guessing what you're asking and saying.

Q I am marking Defendants' Exhibit 15. It is a

one page document, and it has the Bates number PBC 6083. Let me know when you've had a chance to review Defendants' Exhibit 15.

A Yes.

(Thereupon, Defendants' Exhibit 15 was marked for identification.)

BY MS. FAHEY:

Q In Defendants' Exhibit 15, is this an email from you?

A Yes.

Q Is your email address julie@drjuliehamilton.com?

A Yes.

Q Are you the only person who has the password to sign in and write messages from that address?

A I mean, I don't know. My husband probably -- we can get into each other's accounts so...

Q Does your --

A He did not write this letter.

Q Does your husband write emails from your account?

A No. I mean if he did, he would say this is Tyler. He would never sign my name, no.

Q So if there is an email from julie@drjuliehamilton.com with your name at the bottom,

Julie Hamilton, Ph.D, LMFT would that email be from you?

A Yes.

Q In this email you are asking the -- Dear Mayor McKinlay and PB, Palm Beach County Commissioners -- you are asking the commissioners what to do with some clients; is that correct?

A Yes, I was.

Q And what did you do with those clients?

A That's the client, one of them -- I had one in particular where I had to -- I chose to continue working but to change my relationship by restricting my speech so that I wouldn't get in trouble.

Q And which Doe was that? Was that Doe 1, 2, 3, or 5?

A Doe 3. Doe 5 did not continue past the ordinance, was not going on when the ordinance was signed, so Doe 3.

Q Okay. Doe 3. Did you -- you still had Doe 1 and 2 as clients at the time?

A Yes.

Q And did you -- so you changed your relationship with Doe 3. Doe 1 you have not seen since the passage of the ordinance?

MR. MIHET: Objection. Asked and answered.

THE WITNESS: No. Doe 1, the goal -- the -- I

believe I saw this client after the passage of the ordinance, as I said earlier today, but I was not trying -- the client had already shifted in their perception of self prior to the passage of the ordinance.

BY MS. FAHEY:

Q Okay. So I think we have covered what you did with the clients that you were referring to in this email, which is marked as Defendants' Exhibit 15.

MR. MIHET: Form.

THE WITNESS: Yes. You know, I do want to -- oh, go ahead.

MR. MIHET: No. I just objected as to form.

BY MS. FAHEY:

Q So we have covered through the course of our conversation what you've done with each of the clients that you still had?

A We have, yes.

Q Okay.

A But while you have this letter out, I would just like to point out -- because there were so many things that I was trying to say in the short three minutes that we have, so I did follow-up with this email. Incidentally -- well, that doesn't matter, but there are other scenarios where this would come into

play. For example -- could come into play.

For example, if I get a new client tomorrow and they come in for substance abuse and I start seeing them and I'm working on, you know, talking about underlying issues, trying to figure out what's going on, why the substance abuse, what's happening in the person's life, and a year into therapy they finally work up the courage to say, really, they have these same-sex attractions that they don't want and that they were embarrassed to talk about before and they never told anybody before, now they're telling me. According to your ordinance, I would be in the same exact dilemma again. Do I abandon them and say, "I'm so sorry, the county won't let me work with you. We can no longer try to resolve the underlying issues that are leading to your substance abuse because the underlying issues are not issues that I'm allowed to talk about according to the county commissioners"? Do I abandon them? Do I continue to see them and say, "Okay. Well, we can't talk about the real underlying issue, let's talk about other things. Let's just talk only about behaviors and not root issues"?

So this scenario, even though I figured out a way to deal with that one client by altering my speech and having to tiptoe around this topic very difficultly,

this could happen again and again and again and again in the future because things come up as the process unfolds with minors. So I think this is an important point to hold on to as you think through all of this and as your clients think through all of it.

Q Do you have any current clients that you are grappling with the decision about whether to change your relationship with them or to terminate your relationship because of the Palm Beach County ordinance?

A I am not grappling because I made the decision that I wouldn't abandon my client. I would just have to stop my free speech, and I do want my free speech back.

Q And so with -- except for Doe 3 that you've identified for me, are there any other current clients of yours that you have changed what you're doing with the client to comply with the Palm Beach County ordinance?

A No, I haven't. And so I only brought -- what I just brought up was there could be clients that I'm seeing now that could reveal to me they have this issue that I didn't know they had, but currently no.

Q Okay. And interrogatory number 18 -- actually, this will be a new document because this was provided in supplemental interrogatories, so it should be just a two-page. Do you have that one?

A Yes.

Q Okay. So in interrogatory 18, in the substance of your response, you advise that in the year before the ordinance was passed you had 44 total different clients, and I understand that one client may be a whole family unit so that may be multiple people but it's individual clients. Okay?

A Individual units, yes.

Q Okay. And then of the -- of those 44 individual unit clients, you had five minors requesting for help for unwanted same-sex attractions or gender identity within the last year. So five within the 44 clients, is that accurate?

A That's right. That's right.

Q Okay.

MR. MIHET: Within the last year, before the passage of the ordinance.

BY MS. FAHEY:

Q Before the passage of the ordinance. We've discussed your clients after the ordinance, right?

A Yes.

Q And you have told me that there are no clients after the passage of the ordinance that would be any different than the 1 through 11 that we've been talking about?

A Right. Because I had to turn clients away. There were new ones that have approached me, the families had approached me, but I had to turn them away, right.

Q I understand. And so when we are talking about how many minor clients the year before the ordinance passed who had this issue in your practice, it would be five clients, five minors out of the 44 clients. Is that accurate?

A Okay. So, wait a minute. Right. So out of the 44 total units, either families or individuals, eight -- five wanted help, eight -- there were eight that were coming for either sexual orientation attractions, behaviors, gender identity, eight; five wanting some type of change in their life; three not wanting any type of change with regard to that issue.

Q Okay.

A Okay.

Q So as I understand it, we were looking to understand what percentage of your practice involved minor clients who were seeking change, so I would divide -- I would put --

A Right.

Q -- five over 44, and I would get just over 10 percent, about 11-point something percent. Is that

an accurate way for me to calculate approximately the percentage of your practice that, in the year before the ordinance, dealt with clients who were minors who had unwanted same-sex attractions? Is that the way I would get there?

A Yes. Yes.

Q Do you recall whether -- and I understand I only asked you about one year. So I asked you about that one year, give me some numbers, we got that, and I came up with about 11 percent of your practice.

A Okay.

Q Are there years past in your practice where you believe that the percentage of your clientele who were minors seeking help with unwanted same-sex attractions -- they wanted help, that five, not the eight -- were there years in which the percentage of your practice that consisted of that subset of the population you think it was greater than 10 percent?

MR. MIHET: Form.

THE WITNESS: I don't know without looking back at numbers and being able to calculate, but I would speculate that in the future I would see an increase -- if this ordinance were not in place, I would see an increase in the number of clients that are experiencing gender confusion because of the --

and even perhaps confusion about attractions, so children that were not identifying as homosexually-oriented prior.

But like I think I mentioned to you, a recent article came out about sudden onset gender dysphoria, and I think we're going to see more children that are experiencing confusion related to the issues we're talking about today because of the cultural shift that is taking place and because of the access that children have to the Internet, so the numbers that we have currently and the numbers that we have in the past I believe will increase.

We've already -- I mean the statistics will tell you that today, the number of children identifying as transgender is much higher than ten years ago. So I think that if you're looking at what my percentage is -- what it was, I don't remember; what it is now I have given you, but I want to just say that I believe it will increase -- the need is going to increase. Whether we're legally permitted to help them or not, I don't know where this ordinance is going to go, but I believe the need and the number of clients calling and asking for help will increase because we see that statistically already with transgender children.

BY MS. FAHEY:

Q And are the eight individuals that you referred to in your answer to interrogatory number 18, are they identified in your response to interrogatory 22, which was that list of Doe numbers 1 through 11? Is everybody covered on the list 1 through 11?

A So this number 18 is in the last year, how many of them, and that other one was in the last nine years. So let me just double-check, but I would say they would have been then.

Okay. So I don't have it in front of me, so if number 18 is about what clients came in within the last year, and if number 11 was about what clients came in within the last -- no. Number 11 was about which -- how many clients within the last nine years with unwanted homosexual attractions or gender identity confusion, so that list did not include the ones with wanted. You've only asked me for the last year the ones with wanted, but not for the last nine years.

Q Okay.

A You get the difference? Okay. So the unwanted ones would have been on both lists, but the ones who wanted --

Q Got it.

A -- weren't on both lists because that wasn't

the question. Okay.

Q So I understand what you're saying, that the five that's over here in answer to interrogatory 18, the supplemental response, those five are on the list because they were unwanted, but the three that got from five to eight, those individuals would not have been on this list because Doe numbers 1 through 11 did not address any minor who had wanted same-sex attractions?

A Exactly. Yes.

Q Got it. Have you experienced a decline in your profits since the passage of the county's ordinance?

A Okay.

MR. MIHET: Form.

THE WITNESS: And so I want to be very clear because my first instinct when I saw that question was -- as you probably realized earlier when I did become passionate about my statement of harm that's being done, money is -- the loss of income is not my concern at this point. The concern is the damage being done to the children.

So as far as whether or not I have lost income, I have not calculated that and I don't know -- well, I think I had to make a calculation for you guys estimating, but it was -- that's a

wild guess as to whether clients would have even come every week or every other week. So to know how much I've lost isn't actually -- I don't think that's easy to calculate or even there's a way because you just don't know if clients are going to continue beyond one or two sessions or how often they'll come or anything like that.

So I don't know, but I do want it to be on record that that is inconsequential compared to the loss of the damage to these children.

BY MS. FAHEY:

Q Okay. I understand. And I'm not asking today for you to give me a number, I'm asking whether you know if your business practice, since the passage of the ordinance of -- basically in 2018, have you experienced a decline in profits that you know of?

MR. MIHET: Asked and answered.

THE WITNESS: Wasn't there a question where you asked that in writing somewhere?

BY MS. FAHEY:

Q I did, and I'm not asking that question right now.

MR. MIHET: The question is do you know.

THE WITNESS: I think in answer to one of these questions I had to make a guess, and so do I

know if I've lost profits? I -- I -- yeah, I don't -- I would guess that when I had to turn two clients away, they are clients that would have paid me to come, and so I lost the money that they would have paid me, yes.

BY MS. FAHEY:

Q And we've already covered what your charges are. The charge for your session doesn't change based on the client or anything like that?

A No. It's always the same.

Q Always the same?

A Unless I do -- if you are experiencing a hardship, I will adjust sometimes. Sometimes I don't have a sliding scale though, it's $100, but I'll make exceptions for people that are really not able to pay.

Q Have you noticed a decline in the number of new patients that you have seen in your private practice since the passage of the ordinance?

A Well, the two that I can't see, yes.

Q Other than the two.

A Well --

MR. MIHET: Form.

THE WITNESS: -- any others that are going to call -- this is interesting. At lunch I received word of a therapist emailing a colleague of mine to

say "What are the laws in the particular city they're in, which is Palm Beach County. I've just had this teenager that is wanting to come in and [redacted] really distressed about homosexual attractions. Am I allowed to see this person or not?"

I thought that was so timely that that email would come through and I would hear about it at lunch because I just thought "Oh, my gosh, there's another one, another kid who's going to be turned away." And [redacted] distressed, which could turn into depression, which could lead to suicidal ideation. [redacted] not going to get the help that [redacted] wants for living congruent with [redacted] faith. And so, yes -- is there going to be a decline in profits? Yes, because we turn clients away, but the bigger issue is what's going to happen to these clients.

BY MS. FAHEY:

Q I understand what you're saying. What I'm wondering though is have you noticed, other than the two clients you already let me know about, have you noticed in your practice, in the last six months, a decline in the number of patients that you've been seeing?

A Oh, I don't know. I haven't calculated the averages of how many I'm seeing a week versus how many I

was last December, and the months fluctuate as well depending on the season of the year.

Q I understand that you have not terminated any relationships with any patients because of the county's ordinance; is that correct?

A Well, I just --

MR. MIHET: Form.

THE WITNESS: I failed to initiate to, but I have not terminated.

BY MS. FAHEY:

Q Okay. So have not terminated?

A That's right.

Q Okay. And you've already answered to me that you have changed one relationship in particular, and that was Doe 3 that you changed your relationship with because of the county's ordinance.

A Right.

Q Did you refer Doe 3 to any other religious leader for Doe 3 to discuss their --

THE WITNESS: I --

MR. MIHET: Form.

BY MS. FAHEY:

Q Sorry. Let me go ahead and --

MR. MIHET: We'll take turns. Give her a chance, give me a chance, and then you answer if

you can.

THE WITNESS: Okay.

BY MS. FAHEY:

Q Did you refer Doe 3 to anybody else when you decided to make the chance to -- when you decided to make the choice of substantially changing your relationship with Doe 3 in light of the county's ordinance, did you refer them to anybody else?

MR. MIHET: Form, asked and answered.

THE WITNESS: I did not know of anybody else to refer [redacted] to that would be trained to understand this issue and help him or her.

BY MS. FAHEY:

Q So let's talk about you have let me know that there are two clients, potential clients, that you have turned away, and you let me know previously that you were referring -- you spoke about those clients in paragraphs 157 and 158. I'd like to take them one at a time, if you don't mind.

So let's talk about the prospective client discussed in paragraph 157. In your conversation with the person who contacted you about that potential client, did you speak to the minor or did you speak to the parent?

A Parent.

Q Okay. Did you refer that parent to any person whatsoever to address the concern the parent had?

A Well, and I should clarify, the minor was who I turned away. I was able to meet with the parents a couple of times.

Q Are the parents still clients?

A The case is open, but they cannot go any further until they are legally permitted to bring their minor client in to see me.

I mean they could talk about other things but -- yeah, therapy would be much more effective if we could bring the minor client in.

Q Have you --

A And they are waiting for that -- such a time to be able to do that.

Q Have you recommended to the clients described, the parents in 157, have you recommended to them that they speak to any religious leaders?

A Interestingly --

MR. MIHET: Form, asked and answered.

THE WITNESS: Interestingly, I have racked my brain to think of how this child can get help, and I thought, "Well, perhaps they could talk to their religious leader." There's actually a youth pastor that they know. And then maybe since that youth

leader knows nothing about how to help with gender identity confusion, maybe I could coach the religious leader, but the ordinance says that I can't -- the practice of trying to change, so I didn't know if that included the practice of trying to help a pastor help somebody change or what, so I'm at a standstill, but that's an idea that has crossed my mind is to refer to someone in the community who doesn't understand this issue and then maybe I could coach them in how to help the minor client.

BY MS. FAHEY:

Q Did you recommend anything else to these parents? I understand that you're not referring them to anybody else, so is there anything else that you have recommended that they do?

A No. I literally do not know what else to tell them. It's a really -- it's a bind that I'm in. They're just waiting.

Q Now let's go to paragraph 158. Is that the same situation where you have spoken with the parents but not the child?

A I have spoken with the parents, and I also met with the entire family to discuss family relationships. I have not been able to meet with the minor to discuss

the minor's concerns.

You know, I want to back up. In 157, they also had an issue related to a different family member. And so, like I had said before, goals are not like, "Oh, this is the one thing we're working on." We're talking about human relationships and so forth. And so I met this minor because they came in for a totally different reason one time. Does that make sense?

Q Yes.

A The minor was in my office with a family situation not at all related to that minor.

Okay. In the second -- in the 158, the parents and the minors in that family came in as a whole family and we met as a whole family.

Q Okay. And you were addressing family relationship issues not anything related to do with sexual orientation or gender identity, right?

A Well, interestingly, the family issues definitely were related to that, but I couldn't talk about that. So we met one time, we couldn't go any further because in order to continue to resolve --

I mean, you know, I think we accomplished as much as we could, but there's a lot more that's related to the issue that I'm not allowed to talk about. So that was a family session where I was able to talk about

ways of relating to each other but then had to stop short and say, "I can't help you with" -- when the other issues came up, I had to say, "I'm not allowed to help you with that," and so that's where they've been also on hold and not getting the help that they need.

Q Has that family in 158 come in more than once?

A Yes, but not as family. So I think the parents came in -- the whole entire family, one time.

Q Okay.

A The parents, I can't remember if it was one or two times without children.

Q Okay. Is the family that's spoken about in paragraph 158, is that file still open?

A I think so.

Q How about --

A I believe so because they're both just unresolved, just hanging out there waiting.

Q So 157 and 158 --

A Are both --

Q -- the people in those two paragraphs, the files for those clients are still open?

A Yes. Even though, like I said, the services have never been -- the conversations and therapy have never been with the minor about this issue.

So, I want to be clear. In the way I have

described it to you and saying "I turned them away," while the file is open and I was able to talk to the parents about parenting issues and the family about the family issues, the minors have been turned away from being able to talk about their issues, so that's where we're on hold with an open file waiting to be able to bring the minor in to talk about the minor's issues.

Q And when's the last time you met with the family described in paragraph 157?

A They both contacted me after the passage of the ordinance, so I don't remember the last time, but I know that their initial contacts were probably spring, so it would have been sometime between spring and now. It would have been my first and last, does that make sense? So I don't remember the last time.

Q Okay. Did your interaction with them, in-face interactions with them last for longer than a month, either of these two situations, 157 and 158?

MR. MIHET: Form.

THE WITNESS: I don't remember -- I mean, so if they initiated sometime in the spring, maybe March and May, but I don't even know if that's exact, and if I saw the one family -- maybe the parents once or twice and then the whole family together, I don't know if the three times would

have been over the period of a month or two months. I don't remember how it was spaced out.

BY MS. FAHEY:

Q Okay.

A And then the 157 I saw more than -- the parents I saw more than a couple times -- or I don't actually remember the number, but I don't -- again, I wouldn't -- I don't remember if it was like I saw them once and a month went by and I saw them again and another month went by, or if it was all within a shorter period of time.

Q Okay.

A So that's why I don't remember the last -- the very last time I met with them. I just remember they initiated after the passage of the ordinance.

Q I want to take you to paragraph 159. I don't think we've reviewed that yet today, so if you can read that.

A Okay.

Q And in paragraph 159, you advised that you have had many requests for therapy that you've received, right?

A Potentially many clients who periodically received requests for therapy.

Q What I'm trying to understand is 159 a general

statement or are you identifying additional people other than --

So I understand 157 and 158 represent two potential child clients, each of them being 12 years old. Are there any other potential minor clients that you have turned away or been unable to help because of the constraints you feel with respect to the passage of the county's ordinance?

A No. In fact, the wording is just that I receive requests for therapy periodically. I periodically receive requests for therapy. So we're talking about future because throughout my years of doing therapy, this is kind of an issue that people call me for, so the potential for receiving future calls is there. That's kind of what that meant.

Q Got it. So that's the -- 159 covers the more general. In general you receive requests. You don't have anybody specifically that you would be identifying in 159 at this point?

A That's right.

Q Okay. I'd now like to talk to you about some of the presentations that you've given. You provided them, and we have marked for identification purposes two that were PowerPoints. You gave us in response to our request for production some copies of some PowerPoint

presentations. So I'm now shifting -- just letting you know where I'm going.

A Thank you.

Q I'm now shifting and talking to you about presentations you've given.

A Okay.

Q Have you given any presentations to non-Christian audiences?

A Yes.

MR. MIHET: Form.

BY MS. FAHEY:

Q And what I'm wondering is have you -- have you given presentations to an audience that it's not like in a church necessarily or the audience is not gathered for the purpose of sharing a common religious belief?

A Yes.

Q Okay. In what types of audiences have you given -- what types of audiences are you referring to?

A Okay. Conferences that are research organizations rather than religious organizations. I've done -- you know, participated in panel discussions on college campus. That's not at all -- they're not gathering for the purpose of any religious commonality. Media presentations that are not Christian, media outlets.

Q Okay. Have you given any presentations to an audience that was predominantly licensed professionals?
A Yes.
Q And is that the conferences you were speaking about?
A Yes. And then other conferences where there also are licensed professionals, but it's Christian based.
Q Okay.
A So there are other -- so research conferences, associations. You're talking about only on this topic, these topics?
Q Yes.
A Yeah. So, yes, I have spoken to groups of licensed professionals, licensed therapists.
Q What conferences have you spoken at?
A The South Florida Association of Christian Counseling, the Alliance for Therapeutic Choice and Scientific Integrity. Non -- you're talking non -- any conferences at all or just professionally licensed?
Q I'd like to hear more about the different conferences you've spoken at.
A Okay. Restored Hope Network conference. I mean in the past I used to speak at Exodus conferences. I've -- you know, then there are other settings that

aren't conferences, college campuses.

Q Which college campuses have you spoken at?

A Stetson. I believe -- is that the one in Deland? I think so. Yes, thank you. Palm Beach Atlantic. That's all that comes to mind.

Q Okay. Have you given any presentations that qualify for CEU credits?

A Yes, actually. Uh-huh.

Q Were those presentations on the topic of sexual orientation or gender identity?

A They were on the subject of -- they are some of these presentations, some of the similar, yeah.

Q Okay. Which -- so let's go ahead and mark them, and then you can let me know which ones. So I have -- we're now on Defendants' Exhibit 16.

A Okay. So I'll tell you about this one.

Q Okay.

MR. MIHET: Let's wait for her to mark it.

THE WITNESS: Okay.

(Thereupon, Defendants' Exhibit 16 was marked for identification.)

BY MS. FAHEY:

Q So I'm going to mark them, and then we will be able to talk about them, and you can just let me know "I'm referring to Defendants' Exhibit 12" or whatever it

might be, and then that way we can all be on the same page but you'll have available in front of you what it is that we're talking about.

A Okay.

Q So that was 16. Now I have another one. This is going to be 17. My math is getting much better.

A Thank you.

(Thereupon, Defendants' Exhibit 17 was marked for identification.)

BY MS. FAHEY:

Q 18 -- I should be saying these, but 18 is Hamilton 007. And 19 is Hamilton 008 through Hamilton 20.

All right. And there were two that did not have -- that did not yet have Bates numbers. The Bates numbers will be supplied later. We received them yesterday, and those two were Defendants' Exhibit 16 and Defendants' Exhibit 17. I understand that they were discovered in paper copy and that's why we got them yesterday.

A Right. I had forgotten all about them because they weren't on my computer, but I came across them so I turned them in to you.

Q Thank you.

A You're welcome.

(Thereupon, Defendants' Exhibit 18 was marked for identification.)

(Thereupon, Defendants' Exhibit 19 was marked for identification.)

BY MS. FAHEY:

Q Okay. So now I have the presentations that you have provided to me. Which of these have qualified for CEU credits?

MR. MIHET: Form.

THE WITNESS: Well, there was one that I did for CEU credits and then it was probably --

MR. MIHET: Tell her which one.

THE WITNESS: It was probably "Prevention, Early Intervention."

BY MS. FAHEY:

Q Okay.

A Number 13.

Q Number 13, got it. What type of CEU credits would this have qualified for?

A What do you mean?

Q It would qualify for LMFT CEU credits?

A So it's under our -- the licensing includes social work, mental health counseling, marriage and family.

Q Okay. So for any of those licenses?

A Uh-huh.

Q And is there a subcategory like I was explaining -- talking with you about earlier how, in the legal field, there may be a subcategory of ethics CEU credits?

A Oh, right. I'm not aware of a subcategory. Let me say this: They pulled the CEU credits for this, so it may be just a waste of time to talk about it at this point because the CEU accrediting body said that this was conversion therapy, which it wasn't. It's prevention and early intervention, what parents can do for children, how parents can parent in a more effective way, that they're relating to their child in a loving, nurturing way to meet the child's needs, but it had nothing to do with what a therapist says to a child. It had nothing -- there's nothing in here that's even talking about what a therapist says to a child. It's about parenting.

So, that was truly slanderous. They revoked the CEUs and, you know, put the institution on probation. I mean it just seemed like a witch hunt to me. But, anyway, I don't know if you want to keep talking about it because I don't think the CEUs were actually honored in this one.

Q Okay. What institution are you referring to?

A Palm Beach Atlantic University. And it was the South Florida Association of Christian Counselors, it wasn't the school. It was just -- somehow I think the school may have the CEU. I think they partner somehow.

Q Okay. And so is it PBA or the organization that is put on probation?

A I'm not sure.

Q Okay. If it's possible, and you let me know if it doesn't make sense, but I have already talked to you about 12 and 13 as far as them being PowerPoint presentations that you created and you presented.

A Yes.

Q So, if possible, and let me know if it doesn't make sense, I would like to ask you questions about Defendants' Exhibit 16, 17, 18, and 19 to ask whether -- are these exhibits 16, 17, 18, and 19, are these handouts from PowerPoint presentations that you have authored, created, and presented?

A Yes, they are.

Q Okay. Now let's look specifically at Defendants' Exhibit 16 because it has handwriting on it.

A Oh, yeah, my handwriting.

Q Is that your handwriting?

A Yes.

Q Okay.

A And this -- I'm sorry, this is another university. I don't know -- if I didn't give -- apparently I did not give you an exhaustive list of universities. Did you want an exhaustive list? Was that considered an exhaustive list? Because I forgot about this. This is eight years ago.

Q That's okay. Where did you present this --

A Liberty --

Q -- Exhibit 16?

A Liberty University Law School.

Q Law school?

A Yes. Via Skype because there was a blizzard. I wasn't on campus because my flight got canceled, so I did it via Skype. So I actually don't really know where I was presenting, that's why I say that. It's kind of a funny situation, and I really don't know. I think it was the law school, but I didn't actually see the audience.

Q Okay. Look with me to Defendants' Exhibit 19. That's the one with the largest pictures.

A Uh-huh.

Q And at the bottom there's the -- we call it Bates numbers, Hamilton and numbers. If you could turn toward Hamilton 17, and the top slide says "Steps

Towards Change."

A Uh-huh.

Q Can you please explain to me the relationship between the things listed on the side and the header "Steps Towards Change"?

A Uh-huh. Can I explain the relationship between the items and the header?

Q Yes. And so I am hoping to understand from you whether these are, like, stair steps toward ultimate change or whether these are a scattering of things that could lead to change. I'm trying to understand that relationship.

A Yeah. These are what I was saying to you earlier -- this is a good list. I forgot I had this list -- of things that can be helpful to people in changing, and how I do believe therapy is one of the most important things because oftentimes therapy -- in the process of therapy clients -- you can discover what's going to work best for this client. Does the client like to read? So would books be useful? Does the client like -- is the client lacking in friendships? Should we be helping them develop new friendships? You know, that kind of thing. So these are all things that can be helpful, but they're not in any particular order.

Q Okay. So they're not in any particular order,

and you're not saying that every single one of them has to be present for somebody to change?

A Right.

Q Okay.

A These are just things people can do.

Q Okay. Now let's move on to Hamilton 18. Oh, I'm so sorry. We were on that same document, and you were on page 17, so if you could flip to the next page. It is still Defendants' Exhibit 19, but it's that last page -- not the last --

A Uh-huh.

Q So flip one more, there you go, "How should Christians Respond?"

A Uh-huh.

Q And I see that there is an asterisk, and at the bottom it says "Taken from 'How Should we Respond' by Joe Dallas."

A Uh-huh.

Q Are these things that you would present as the model for how a Christian should respond?

MR. MIHET: Form.

THE WITNESS: I think this is a very old presentation. I developed this one a long time ago, I think. This slide, I started using that probably 13 years ago. You probably have a copy of

my video. I talk about that in there, which was published in 2005.

So, I don't know. I don't recall -- I don't know if I would change this now or not. I might. Yeah, I might. I'm not sure.

BY MS. FAHEY:

Q And --

MR. ABBOTT: Excuse me. May I just state for the record that the exhibit the witness is referring to is Exhibit 20. It may have been misidentified.

MR. MIHET: No, it's 19.

MR. ABBOTT: Oh, it is?

MR. MIHET: Yeah.

MR. ABBOTT: I said one thing in the deposition and it was a lie, right. Thank you very much.

BY MS. FAHEY:

Q And so what I am wondering is: Is that asterisk taken from, you know, Joe Dallas, is that you communicating to the people you're presenting to that you don't endorse these things as "How Should Christians Respond?" or is that you giving credit to Joe Dallas?

A Giving credit.

Q Do you believe presently that the appropriate

response for a Christian to a moderate homosexual is to model God's love?

A Yes.

MR. MIHET: Form.

BY MS. FAHEY:

Q And do you believe that an appropriate response for a Christian, with respect to a repentant homosexual, is to walk alongside them in their journey?

MR. MIHET: Form.

THE WITNESS: Yes. Now this wasn't to a therapy audience, okay, so just for clarification. So my role as a therapist may go beyond this, but to the average person, yes, I think that we should do that for anyone who's -- and those are his words "repentant homosexual," so someone who's seeking change is what he meant by that.

BY MS. FAHEY:

Q Do you embrace this model of how to respond to three different -- and I understand that you might not agree with the labels as far as "militant homosexual, moderate homosexual, or repentant homosexual," but do you embrace this model for your own behavior as a Christian, "defend without attacking, model God's love, walk alongside in their journey"?

A Uh-huh.

MR. MIHET: Form.

THE WITNESS: I think this would be an example of that. I believe I'm defending the rights of my clients and for me to have free speech, and I believe I'm doing that without attacking their character or personhood. And so, yes, I believe that's how -- you asked me if I personally believe in this?

BY MS. FAHEY:

Q Yes. I'm not asking you --

A And I do, and I'm giving you an example of that, yes.

Q I'm not asking you to reflect on your behavior in any way, I'm just asking if you endorse Joe Dallas's prescription for how Christians should respond.

A Yes. Whether I would add to that or not now, I don't know. Like I said, 13 years ago I started using this model, but I don't know if this is the exhaustive list of how Christians should respond, but it was a good summary at the time, and I don't disagree with it.

Q Let's look to Defendants' Exhibit 16. It's that one with handwriting. When did you create this presentation?

A I'm going to guess it was 2010 because of that date.

Q Okay.

A Yeah.

Q And would you give me the benefit of reading the handwriting? I know that this copy is not very dark, but just in case there are issues with interpreting the handwriting.

A So they were probably my notes to --

Q Okay.

A -- jar my memory when I was going through the presentation. So introducing NARTH as the scientific organization.

The next slide I wrote notes that there were six people plus one staff liaison before the task force. I don't know what that word is, but names had been submitted. So other names were submitted that the task force denied, just like it says on that slide there.

The innate/immutable is what the next thing says. They dismissed studies showing that change is possible. They highlighted the flaws of those studies, and that we're referring to that report that you all have as the basis for your ordinance. They dismissed the studies showing that change is possible. They highlighted the flaws of those studies. But when it came to the studies that would promote only affirmative therapy, they ignored those laws. That's what the

writing says there.

Q Oh, okay. And so not all of the words you just said are actually in the handwriting?

A Right. Sorry, I elaborated.

Q No, that's okay. If you could --

A Sorry. I was explaining what they meant. Okay. I'll just read the words.

Q And it looks like there was -- on the second page it looks like there was some handwriting, but it didn't show up clearly on this copy. If you could go down to the bottom, and to the extent that you can read your handwriting, let me know what that says down there.

A Okay. "Clearly biased report. While they did acknowledge that some may seek change for religious reasons, they offer very limited" -- I don't know what the next word is -- on how -- I think it says -- oh, for those clients maybe. So they -- did that make sense?

So while they did acknowledge that some clients may seek change for religious reasons, they offer limited opinion on how those clients -- in other words, how those clients could seek change because they're not recommending therapy. I think that's what that means. I'm not positive.

Q Now let's look at Defendants' Exhibit 17 together. I see that there's a date at the top, 2013.

Would that be when you prepared and presented this presentation?

A Probably, yes.

Q And where did you present this presentation?

A Palm Beach Atlantic University.

Q Would that have been -- you presented at Palm Beach Atlantic University. That would not have been as an assistant professor, right?

A Right. I was done working there at that time. I came in as a guest lecturer into someone's class.

Q When's the last time you presented this presentation?

A I think that was the only time I presented it. Well, I mean I'm not sure but... I don't remember presenting it again.

Q Now will you turn -- I'm still on Defendants' Exhibit 17, turn to page 4. And there is a slide at the very bottom right that says "What is this Therapy?"

A Uh-huh.

Q The third bullet point says "There are many forms of therapy that are used successfully with this population, including: Cognitive therapy, reparative therapy, interpersonal therapy, EMDR, family therapy, narrative therapy, as well as other forms of therapy."

Now I understand that you have told me that

you do practice family therapy and that you do not practice EMDR. Do you practice cognitive therapy?

A No.

Q Do you practice reparative therapy?

A No.

Q Do you practice narrative therapy?

A No.

Q But you do practice family therapy?

A Yes.

MS. FAHEY: Can we take a quick comfort break? I am going to set up my laptop real quick.

(Thereupon, a short break was taken from 4:12 p.m. to 4:24 p.m.)

BY MS. FAHEY:

Q Okay. So Dr. Hamilton, you produced to the county a video DVD called homosexual 101, correct?

A Yes.

Q Okay.

A "Homosexuality 101," yes.

Q I'm very sorry, "Homosexuality 101." And I'm going to show you Defendants' Exhibit 20. Defendants' Exhibit 20 is a page from the website drjuliehamilton.com. And on your website you list, under "Resources," the "DVD: Homosexuality 101," right?

A Yes.

(Thereupon, Defendants' Exhibit 20 was marked for identification.)

BY MS. FAHEY:

Q Okay. That is the DVD that you produced to the county?

A Yes.

Q This video was produced by or in conjunction with Exodus Ministries, correct?

A It was produced by me, but yes -- let me say I probably -- this is -- you know, I'm not a big high tech person, so I don't always keep up with changes that probably should be made to my website. I did have a website designer recently just try to clean things up for me, and this DVD is actually not in circulation. I don't -- he found someone that is selling it supposedly, but I don't know how they would be selling it because they don't have copies. So I think if you click on that link to actually purchase it, I don't think you can purchase it. I probably need to get that link off of there. It's just negligence on my part of just not keeping up with my own website.

So this is not in circulation. I have not sold this in years. I don't -- I think I know this person. I know there's a link to someone's website and that person did buy copies from me, but probably ten

copies, and they were like -- it was probably years ago, probably 2012. I don't even know when, but years ago so -- or he probably only bought five copies, I don't know. I doubt this person has any copies to sell, but he would be the last standing person that is selling this DVD.

So just for the record, it is not in circulation at all. It's outdated. Obviously Exodus doesn't exist, it's outdated.

Q Okay.

A It's 13 years old.

Q Okay. Is it still a resource you would recommend to an interested client if they were to say --

A I don't --

Q -- "I would be interested in resources on the topic of homosexuality." Is this DVD something that you would recommend to them or provide to them?

MR. MIHET: Form, assumes facts not in evidence.

THE WITNESS: They wouldn't have a way to get it, so it's not one that I recommended in recent -- I can't -- but they can watch the gist of it online so...

BY MS. FAHEY:

Q When's the last time you reviewed the video,

"Homosexuality 101"?

A I haven't watched it in a long time.

Q Okay. So I was going to ask you if there was anything in the video that you know longer endorse or believe is accurate or up-to-date?

A Well, yeah --

MR. MIHET: Form.

THE WITNESS: -- Exodus is gone. But, yeah, I mean it's just an outdated video.

Again, if I was a web person myself, I probably would have taken it down, but I need to contact the guy that did the website and pay him some money and get him to take it down probably so...

BY MS. FAHEY:

Q And is it your intention to take down the whole resource or just that "Order the DVD, click here"?

A I guess I'd have to think about it because I don't know that I'd want it on there if I can't point them to how they would get it probably. I don't know. I'd have to think about it.

Q So I just want to ask you about two small portions of the video.

A Okay.

Q And so I am going to play that here, and our

madam court reporter may ask me to play it again so that she can get it down.

A I talk fast in it.

Q Ready?

A Yes.

MR. MIHET: For the record, can we say for the record the minute and --

MS. FAHEY: Yes.

MR. MIHET: -- hour, minute, and second?

MS. FAHEY: Okay. So I just backed it up ten seconds, so that was a little bit farther than what we were going to do, but this is starting at 13:49 into the video.

THE WITNESS: Okay.

(The video begins playing.)

MS. HAMILTON: "He wants to attach to the father because God has been in the heart of every child that desire for connection, especially with their parents and with the same-sex parents as well. And so that child is craving for that, and he might try to attach to his father, but if he senses rejection, he will try a few times, but he will eventually give up trying because we can only handle so much rejection."

(The video is stopped.)

THE WITNESS: Uh-huh.
MR. MIHET: For the record, we stopped at?
MS. FAHEY: 14:14.
BY MS. FAHEY:
Q Now that last portion, "we can only handle so much rejection," is that something that you still believe is true and would present to people?
MR. MIHET: Form.
THE WITNESS: Okay.
MR. MIHET: Assumes facts not in evidence.
THE WITNESS: So we can only handle so much personal rejection of our -- of our personhood.
I was describing there a child feeling like the father did not want a relationship with the child. That's the type of rejection that I was talking about, and so I believe that that type -- yes, I would adhere to that if we're clarifying what -- what I was actually saying there.
BY MS. FAHEY:
Q And I understand that you made that statement after talking about the theories of attachment that you were talking about. Do you believe that it can hold any -- does it hold true in any more broad sense where a child can only handle so much rejection?
A Okay. And again, just so we breakdown the

word "rejection," a child -- a parent's rejecting the personhood of their child is very hurtful and detrimental to their child.

While a parent's rejecting behaviors of their child, it is not detrimental in the same way. And in fact if a parent is rejecting drug addiction or illegal conduct, conduct is not rejection of personhood. So if a parent is saying "I don't approve of your life of using drugs," I would say that type of rejecting a behavior that is harmful to the child would actually be helpful. Rejecting an adverse, harmful behavior is helpful. So I just want to make sure we're talking about rejecting a personhood, rejecting that person as a whole is -- parents -- children need love from their parents. Love sometimes does include parents disapproving of behaviors. Okay.

Q Does that complete your answer?

A Yes.

Q Okay. So now I'm going to play the second portion that I wanted to play. And I started it a little bit early just so you can get a little bit more context for the part that I'm going to ask you about.

A Okay.

Q And this video I'm going to start playing at 48:26.

A Okay.

(The video begins playing.)

MS. HAMILTON: "... happy to live their lives. To the moderate homosexual, we must model God's love. It is not up to us to go around making sure that homosexuals become heterosexuals."

THE WITNESS: Yes.

(The video is stopped.)

BY MS. FAHEY:

Q Do you agree --

MR. MIHET: I'm sorry. For the record, we stopped at?

MS. FAHEY: Thanks, Harry. 48:39.

BY MS. FAHEY:

Q My question is: Do you still agree with that statement, that it is not up to us to go around making homosexuals heterosexuals?

A Okay. So I agree with what I was talking about there, and I agree in the therapy office that it is not my job to try to make a homosexual become a heterosexual.

In this context, I was talking in general to people not about therapy, obviously, but that we should not be looking at how to change people's sexual orientation in our everyday relationships with people.

I went on to talk about that the most important thing that any of us need and that any of us should be concerned about with those we love or care about is their relationship with God. Just to make sure we have the whole context of that, that I was saying that there's nothing more important than if you love someone, you care about their relationship with God, and so rather than think "Oh, this person's gay, let me address their homosexuality," I was saying that we should seek to model God's love to them so that they will want a relationship with him because coming into a relationship with our creator, I believe and was saying there, is the most important relationship we can ever have.

And so I -- my point was let's -- let's let God's love shine through us for people to see that. And so I -- yeah, I would definitely still agree with that. In the therapy office I think it kind of -- it kind of backs up what I was telling you today is that I'm not trying to make gay people straight, I'm trying to help them accomplish their goals, and so I think what I was saying there 13 years ago is consistent with how I still practice and --

MS. FAHEY: Are we good on the time? Did I say it correctly?

MR. MIHET: You did. I'd like to get on the

record how long the entire video is, if we can, when it's appropriate. Did we cut you off?

THE WITNESS: No. I think I was good. Thanks.

MS. FAHEY: Okay. Do you want to state it?

MR. MIHET: Does that show --

MS. FAHEY: I believe that that is the full amount of the video.

MR. MIHET: I'm not seeing that because of the time.

MS. FAHEY: Oh, over there. So what's there? 51:12.

MR. MIHET: 51 minutes and 12 seconds is the length of the entire video.

MS. FAHEY: All good?

MR. MIHET: Yes.

BY MS. FAHEY:

Q Now we just said it was 51 minutes long. We don't have time to go -- to listen through this and for me to ask you questions about it. I watched it, and I heard you in this video talk about what I assumed were the theories of attachment and prenatal [sic] nurture that you were referring to in interrogatory 7.

And generally -- I am not qualified to talk about what the theories are, but generally as I

understood it, you were talking about a person's development, boys and girls, and how they detach from the mom, attach to the dad, whether there's a breakdown in that relationship, their attachment and identification with same-sex peers; and then when they enter puberty, they have this interest in the opposite sex and they then become "Wow, I'm interested in relating to that opposite sex in a sexual romantic way." And that when there are breakdowns along the line, that attachment -- the theory of attachment explains how a person might be more interested in the same sex when they get to that developmental stage of puberty.

So that's what I understood you to be referring to as theories of attachment and prenatal [sic] nurture theories. So theories of attachment at least.

A Yes.

Q So do you know whether, in the last 13 years, the theories of attachment have changed substantially from what you would have been presenting in this video that was 51 minutes long?

MR. MIHET: I'm going to object as to form, and I believe that the video speaks for itself. Go ahead.

THE WITNESS: So I still adhere to what I said

on that video, and I'm impressed that you got it all and could repeat. You were able to succinctly describe the idea, uh-huh.

BY MS. FAHEY:

Q Okay. And so that's what I was wondering is if this is still an up-to-date theory.

A Yes.

Q Okay. Then --

A For some people. It doesn't fit for everybody. That's why I said we see does that fit for the client and, yeah.

Q Do you recall whether this video contains the explanation for the prenatal [sic] nurture theory?

A It was actually parental nurture.

Q Parental nurture.

A Sorry. So it has nothing to do with prenatal anything, in my talks anyway. And parental nurture is what I -- yes, that's what I'm talking about there. Like the parents showing interest in the child, bonding with the child, nurturing the child, being loving, affirming, affectionate, yes, all of that.

Q Okay. Then we are good with the video.

Now I, on one of our breaks, printed out the supplemental materials so you now do have them in this binder.

A Okay.

Q And with what little time I have left, I did want to ask you about some of the articles that were produced, when you remember having reviewed them last, or first. And in some instances, particularly I had questions about articles that were talking about pornography, what those pornography articles have to do with sexual orientation or gender identity.

So I am going to point you to PL -- we'll start with 81, and I might ask you to go ahead and take the reins on your own binder while I work on my binder.

A Okay. What was that number?

Q 81.

A Okay.

Q So PL 81, and I say PL, PL Joint 81. The title is "Adolescent Pornography Use and Dating Violence Among a Sample of Primarily Black and Hispanic, Urban-Residing, Underage Youth." Do you recall when the first time you reviewed this article was?

A It may have been this week.

Q And feel free to refer to the Abstract. We're not here to read through every article together.

Do you know what -- what does this article have to do with sexual orientation or gender identity?

A I believe this one is showing how pornography

use affects a minor, a person's thinking and their brain, and how pornography use can affect a client that wasn't necessarily -- and so I think we draw a connection with the fact that a minor who wasn't identifying as gay or lesbian prior to adolescence, and maybe didn't even show any signs of that being an issue for them, encountering pornography can affect their brain and can change their perceptions of self, their perceptions of others, their outlook, their interactions, their behaviors.

So I think that was the point with this is that children can have no -- you know, show no signs of that being an issue in their lives and then encounter something that changes their perceptions and it becomes an issue, and that your ordinance even bans us from helping those children. It's not just about the children that were always demonstrating either gender nonconformity or later homosexual attractions.

Like I said before, I think the originators of the ordinance seemed to have that typical client in mind and we're seeing -- and so the ordinance wipes out every minor that ever wants help no matter how they ended up with those attractions. I think this article just speaks to the fact that pornography affects the brain and affects children, and we can't help those children.

Q Okay. So I understand you to be saying that this article provides like a building block or stepping stone to infer further about sexual orientation or deduce further about sexual orientation, but the article itself may not specifically talk about sexual orientation?

A Well --

MR. MIHET: I'm going to object, and the articles speaks for itself, but you're asking her about what she --

MS. FAHEY: What she knows about in this article.

MR. MIHET: Okay.

THE WITNESS: Right. So I think the point that we bring pornography into this discussion at all is just to say that your ordinance is preventing us from working with children who have been affected by pornography, and pornography does have an effect, so I think this is just demonstrating there is an effect. It's not something, you know, "Oh, I stubbed my toe." It affects children in profound ways. I think that's why I put this in there.

And then to make the point that even the ones who just stumbled into pornography and are now

sexually confused have to be turned away due to the county and City of Boca Raton's ordinance.

BY MS. FAHEY:

Q Let's turn now to PL Joint 230, a big jump there.

A And, by the way, in answering, I would -- there's a lot of articles here, so I'm not remembering everything in this article. So whether it mentions same-sex attractions or not, I don't remember if this specific article mentioned that, but I'm just saying why I think we are bringing up pornography.

Q Okay.

A Okay.

Q So your answer to this one might be completely identical, and I don't want to make you repeat yourself, so we'll just get it on the record one way or another whether it's the same.

So PL Joint 230 is the first page of an article titled "Is Internet Pornography Causing Sexual Dysfunctions? A Review with Clinical Reports."

A Okay.

Q When's the first time you reviewed this article?

A This one may have been this week also.

Q And is this the same situation where you're

providing this article as -- for the same reason as the one we just spoke about?

A I would say yes. Without reading it again in its entirety, most likely that is why we're bringing up pornography at all.

Q Let's flip then to PL Joint 255.

A Again, just to say, so the point is how it changes sexual appetites. I think this article specifically was talking about -- I don't remember if it was this one, but young guys who are having sexual performance issues because of pornography.

So if anyone would say, "Oh, pornography really doesn't change your sexual attractions or your sexual experiences," I think this article is simply proving that young guys -- we never -- you know, it's -- not as common for young men to have sexual issues at the level that they're having them now, and so we're saying pornography has made a difference for them. And we would also say that for children, it would make a difference in their sexual appetites and desires and arousal happens.

Q Sorry. Did I cut you off?

A That's all.

Q But that article was specifically addressing sexual dysfunction referring to physical issues with the

people in that study, right?

A I think it was talking about -- well, I mean I didn't read the whole thing so I could be wrong, but I think it's about -- yeah, it's not about homosexuality. We're just trying to make it clear that pornography affects sexual desire, arousal, and so forth, and this is a study on men, so, my goodness, if it affects men to where they're not even -- they're having erectile dysfunction under the age of 40, imagine a child whose brain is not in any way prepared to handle the types of scenes that are on the Internet on their personal telephone -- cell phones.

And so I think this is just a clear example that if a man ends up with erectile dysfunction, how is the child affected? The child will be affected by pornography exposure. Not always developing same-sex attractions, they may end up with other implications. Some may get just sexually confused or even turned off and just horrified and traumatized by the sight of it.

So this is just making the point that of course if a grown man is going to be affected in his arousal patterns, then certainly a child is going to be affected in a profound way because their brains can't handle pornography. Okay.

Q So you were looking now for PL Joint 255.

When did you first review this study? The title of it is "A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change."

A Probably in 2011 when it came out.

Q And do you agree that this study addresses religiously mediated approaches to change?

A Yes. This is the study I was referring to earlier that was about ministries and ministries can be very helpful. Unfortunately, there are no ministries in Palm Beach County. And there were not any ministries that I ever was aware of that offered help for minors. Yeah, I don't think there was. Maybe in Portland maybe, Oregon. So nothing around here for minors. But, yes, this was about ministries and it's about therapy.

Q And the authors of this article are Jones and Yardhouse?

A Yardhouse, yes.

Q So let's go ahead and turn it -- it appears to me that the next one is related to this one. It's PL Joint 280.

A Yes.

Q PL Joint 280, the title of this article is "Ex-Gays? An Extended Longitudinal Study of Attempted Religiously Mediated Change in Sexual Orientation." The authors being Jones and Yardhouse.

A Uh-huh.

Q Is it your understanding that this is -- this is related to the article we were just looking at?

A Yes. This was their first report, and then they followed up four years later, and the 2011 one was the follow-up.

Q So still the focus of this study is religiously mediated approaches to change?

A Yes. They were looking primarily at people who had gone through ministries, although I will say that some of their participants did receive therapy also. There were -- but they were primarily looking to understand how -- if change occurs or not, and the population they used were ministry recipients while --

So that was kind of how they got their clients was through ministries, but some of them did receive therapy. And I think they were looking more at can change occur for people, so not comparing what's more beneficial or anything like that, yeah.

Q And so do you recall when you first reviewed this article that begins on PL Joint 280?

A I -- this became a book, and I have the book, and I got that when it was first published. It may have been '09, I don't remember, so I would have read it when it came out. I thought it was '07 though to be honest.

Q Okay.
A This may have just been a presentation later.
Q Let's flip to PL 291.
A Okay.
Q PL 291, the title of this article is "Sexual Fluidity in Young Adult Women and Men: Associations with Sexual Orientation and Sexual Identity Development." The author is Sabra L. Katz, K-A-T-Z, hyphen Wise, W-I-S-E. When did you first review this article?
A This one might have been this week.
Q Would you agree that this article, it studied adults ages 18 to 26? And I'm looking at this Abstract, I think that's what you call it, and it's the third line.
A Uh-huh.
Q So this studied adults 18 to 26 years --
A Yes.
Q -- of age?
A And these studies -- again, I think one of the underlying assumptions in the ordinance is that change does not occur. And so, you know, I know that you wanted to see studies on minors, but we don't have studies on minors to show a basis for the ordinance either. We don't have studies on minors that show harm.

We don't have studies on minors that show -- here's what we don't have: Studies on minors or adults that show that clients who are distressed about their attractions will benefit from affirmative therapy.

So in the ordinance, we are allowed to provide affirmative therapy. In other words, we're allowed to affirm their homosexuality even if they don't want it. We're allowed to help them transition to the opposite sex. Even if that's not what they're looking for, we're allowed to do that. But there is no research on minors that has ever been done that shows that it is safe to offer affirmative therapy to minors who are distressed about their homosexuality.

I mean common sense would tell us it's not helpful to push a minor in a direction that conflicts with his religious views and is causing distress already, but there is no research that backs up what is recommended in the county's ordinance. And so we submitted this research here because one assumption of the county's ordinance is that change doesn't happen. It's impossible for change to take place in orientation, which means attractions or behavior and so -- specifically attractions.

These studies show, though they are not done on minors because a lot of studies are not done on

minors, they show that sexual attractions are fluid, that people do change in the area of attractions. And to create an ordinance that says we're not allowed to help people change in an area that's changeable is really kind of astounding.

In fact, I just have to say one other thing and then I'll stop, but this ordinance is actually telling us we cannot change the changeable. We cannot change perceptions or behaviors or mannerisms or gender identity, which again is perceptions of self. We cannot change the changeable, but we can change the unchangeable, which is biological sex, so we can assist them in a transition to change their biological sex.

Obviously we can't administer hormones or surgery, but the fact that we can support them in becoming the opposite sex when every cell of their body contains -- almost every cell of their body contains an XX or an XY chromosome, it's impossible to change biological sex. But the county is suggesting that I can offer to help children change biological sex, but I can't help them change their perceptions of themselves. It's just crazy.

So the reason we have these articles, if you're wondering what the connection is between helping minors, the connection is change is possible. And areas

we're offering to change -- to help people pursue change have been out -- you know, have been banned by the county. So, anyway, yes, we can go through the articles on change, sexual fluidity.

Q Okay.

MR. MIHET: I'm sorry. Did you have a question?

THE WITNESS: Sorry.

MS. FAHEY: I don't think that one had a question.

THE WITNESS: Okay.

BY MS. FAHEY:

Q So we already talked about the fact that 291 dealt with adults. We're going to move on to PL Joint 440, so another little big jump right there.

And the title of this article is "Internet Pornography Causing Sexual Dysfunctions? A Review with Clinical Reports." I think this is a repeat from before.

A It looks like it.

Q So if you would just let me know, was this provided for the same reason as the other two with respect to the reason for providing pornography articles?

MR. MIHET: Form.

THE WITNESS: I would say that would probably be the point of this.

BY MS. FAHEY:

Q So let's go now to PL Joint 465. This might be the same answer, I'll ask you: PL Joint 465, the title of the article that begins on this page is "Neuroscience of Internet Pornography Addiction: A Review and Update." Do you know when the first time you reviewed this was?

A Probably this week.

Q And was this provided for the same reason as the other pornography articles we've already discussed?

A Yes. We're trying to establish that pornography changes adults and certainly would change children.

Q My next question pertains to PL Joint 511.

A And can be addictive, by the way. This is not only that change occurs, but it can be addictive would be the point of this particular article. And so children discovering pornography as young as seven, eight, nine, ten years old, there's major, you know, damage that can be done if they become addicted as a child. And so another reason why we need to have this ordinance is so that we can help them clear up the confusion that results from their pornography exposure

and possible addiction.

Okay. So what was the next one?

Q 511.

A Okay.

Q So 511, that article is titled "Retrospective Self-Reports of Changes in Homosexual Orientation: A Consumer Survey of Conversion Therapy Clients." The authors appear to be Nicolosi, N-I-C-O-L-O-S-I; Byrd, B-Y-R-D; and Potts, P-O-T-T-S. When did you first review this article?

A I became familiar with it probably many years ago. I think it's cited in probably most of my PowerPoints.

Q And if you would please turn with me to page -- at the bottom is 522. So under the heading "Discussion," there's -- I'm three paragraphs down. It starts with "We also cannot." Do you see that part?

A Uh-huh.

Q "We also cannot draw any conclusions about what types of conversion therapy may be most helpful."

A Uh-huh.

Q And then examples, "psychoanalytic, reparative, cognitive, behavioral, spiritually oriented, et cetera," that's the end of that sentence.

A Uh-huh.

Q You would agree that this article does not specifically study what type of conversion therapy may be most helpful?

MR. MIHET: Form. Article speaks for itself.

THE WITNESS: Right.

BY MS. FAHEY:

Q Let's turn now to PL Joint 537.

A But this article does show change. I mean, in fact, it shows that a very high percentage of people changed in this particular study. So, again, it's not specifying what type. Every city has their limits on what they're trying to show or not show.

They were trying to show change, and I think it says that -- well, no, I'm not going to take the time to go through this. You didn't ask me about it, but this showed a high percentage of change for the participants that were in their study. So what was the next one?

Q 537.

A Okay.

Q And the title of the article that begins on PL Joint 537 is "Same-sex parenting and children's outcomes: A closer examination of the American Psychological Association's brief on lesbian and gay parenting." Do you recall when you first reviewed this

article?

A Uh-uh. It could have been this week. I'm not sure of when I saw this.

Q Is this an article that informs your practice as a therapist?

MR. MIHET: Form.

THE WITNESS: I don't work with a lot of same-sex parents, so I'd have to read the article to recall the connection with working with minors. I don't really remember.

BY MS. FAHEY:

Q Okay. Would you go ahead and take a look at the Abstract, that little paragraph right there on page 1?

A I think this article --

MR. MIHET: She hasn't asked you a question yet.

BY MS. FAHEY:

Q And my question is: How is this article related for you to sexual orientation in minors and gender identity in minors?

A I would say I don't know that this article has a direct link to the type of work that I am doing with minors. I think maybe the one thing that where this is relevant is that it's an example of APA's bias and false

reporting of research outcomes, claims -- making claims that weren't really substantiated.

And so I believe, with only having read the Abstract, that this article is showing that, you know, the APA reported I would -- I would probably -- the way I would probably describe it in lay terms is that many of the professional associations have been highjacked by political correctness and are no longer putting forth data that's scientifically based but is instead politically motivated. I think -- to be honest with you, I think the situation with the county is an example of that, that legally it doesn't make a lot of sense that this ordinance got passed, but I think there's political pressure by groups to pass ordinances such as this.

I mean we saw this two years ago. The county was approached and nothing happened, but instead HRC went city by city, convincing commissioners of cities to pass this ordinance one by one, and the first one in Palm Beach County was West Palm Beach. And in those meetings the attorney actually said, "I think we're in good standing because Wilton Manors and Miami Beach have done this." So it was this mentality that because others have done it, we can too. And so one by one I watched city after city in Palm Beach County pass this

ordinance because -- for political reasons not because of scientific, not that anything about this ordinance has been proven to be safe and effective for children, and it was politically motivated. And then one by one, as they passed it, it gained momentum because finally then HRC somehow I think -- or someone demonstrated at the county, "Well, all these cities have done it, so you should too as a county."

So I think this article demonstrates organizations like the APA, who the ordinance cites as the authority on this, do put out research that's just not accurate, and so I guess that would be the main connection that I would make about this.

Q Let's look now at the article that begins on PL Joint 554.

A Oh.

Q And the title of the article that begins on PL Joint 554 is "Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation." The author is Spitzer, S-P-I-T-Z-E-R.

A Uh-huh.

Q Do you recall when the first time you reviewed this article was?

A Years ago.

Q Now I would like, if you could, please turn with me to PL Joint 558, a page of this article. And I'm going to be looking at the section that begins "Temporal Sequence of Sexual Arousal."

A Uh-huh.

Q It states, "The mean age at onset of sexual arousal to the same sex was 12 years (SD equals 2.9). About 18 years (SD equals 7.8) later, at age 30, was the beginning of the therapy that they found helpful."

A Uh-huh.

Q So do you understand this article to be reporting that the participants that they studied, the age where they began to find therapy helpful was age 30 --

A So --

Q -- for these participants?

A -- for these participants, they found therapy to be helpful at age 30; however, I would say that with any therapeutic issue, the earlier we intervene, the better. Whether it's eating disorders, substance abuse, the less time a person has to reinforce something that is distressing to them, the easier it will be for that person to make changes in their lives.

So even though these people found help, started getting help at the age of 30 and they were

successful, many of them, in experiencing changes that they were seeking, this article is in no way saying that it's better for a child to wait until adulthood. That would be not even -- that's definitely not being stated here, and that would not even be logical.

We know that the earlier you catch something, the better. It's true of any -- I mean think about if you start to get sick. The earlier you catch it before it develops into something more, you know, the better in our own physical bodies as well as just in our lives in general.

Q But you wouldn't liken same-sex attractions to being sick, right?

A No, I definitely would not. Thank you for that clarification. That was, again, a loose metaphor.

Q Loose metaphor, got it. But as far as what this study that we're looking at right now, the 200 participants one, this one studied participants who began to find the therapy helpful at age 13 -- 30. I said 13.

A 30, right, right.

Q 30.

A They -- they started therapy at 30, and they found therapy to be helpful.

Q Right.

A But they wouldn't say that was the ideal age to enter therapy. This is just -- it says here that -- yeah, yeah. For them, that was the time.

Q So with respect to the 200 participants, what we're looking at is individuals who received therapy as an adult, right?

A In this study?

Q Yes.

A Yes. That's right.

Q Okay. And this study did not examine any particular method of therapy, right?

A I don't remember. Probably -- I mean if you -- it might be safe to say that. The main goal of Robert Spitzer was to find out whether change had taken place or not.

He actually was, from what I recall, one of the ones who helped lead the charge to declassify homosexuality. He was on the committee that decided to take it out of the DSM and said that it's no longer a mental disorder. And then he was running into people, and I think it might have been a protest at a convention, people saying "But we exist. We really can change." And I think he was a compassionate man and he became curious, "Did these people really change?" So he set out to conduct a study. And that it was very

honorable of him to do something that was --

He received a lot of criticism and a lot of harassment for the results of his study, but -- and mainly, anyway, his point wasn't to compare types of therapy. I believe his whole question was "Can people really change? We've just given a whole new meaning to, you know, homosexuality by declassifying it, but we didn't realize that there are people that would want to change, and can they really change?" So, anyway.

Q Okay. So that comports with my understanding as far as this is not identifying a specific form of how to change, it is identifying whether change is possible, right?

A That's right.

Q So if we could stay on that article for just a moment, I'm looking at page 564. And the very bottom of the first column, the paragraph begins with "The participants in the study all believed."

A Uh-huh.

Q Okay. All right. So "The participants in the study all believed that the changes they experienced were due primarily to their therapy. However, the lack of a control group leaves the issue of causality open. It is logically possible that a small proportion of gay men and lesbians change their sexual orientation without

therapy and that the changes experienced by the participants were causally unrelated to their therapy." Is that under -- is that your understanding as well of this article?

A Yes. He goes on to say, "The issue of causality can only be answered by a study with random assignment of gay men and lesbians wishing to change their sexual orientation..." Yeah, so this study was limited in the claims it could make.

Q Okay. So let's go now to PL Joint 569. And the title of this article that begins on PL Joint 569 is "Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study." There are several authors that I'm not going to list right know. When is the first time that you reviewed this article?

A I think a few weeks ago I was told about this.

Q Is this article being provided for the purpose of showing that there are negative side effects to hormones that are consumed by people who consume hormones for the purpose of transitioning their gender?

A Yes.

Q Is there any other purpose that you'd like to state for this article?

A Thank you --

MR. MIHET: Form.

THE WITNESS: -- for asking. Because in the ordinance, the only thing we're allowed to do is support a gender transition. And as asked earlier today, would I ever encourage a confused boy to start wearing a dress? The more a child does progress down that road, with dress and name and appearance and identifying publicly as that gender, the more likely they are going to be to continue down that path and that path might some day include hormones.

And so it's very important to note that what is being allowed under this ordinance has severe health side effects and health risks, and what's being disallowed under this ordinance is talking, conversations. We're not allowed to have conversations, but we could encourage a boy to start wearing a dress knowing that it may lead to puberty suppressing hormones prior to the age of puberty, beyond the onset of puberty, and then these types of hormones, cross-sex hormones later.

And so this article needs to be taken very seriously by your clients, I would say, the commissioners.

BY MS. FAHEY:

Q Okay. Let's look at PL Joint 767, so another

big jump right there.

Okay. The title of this article is "Effects of Therapy on Religious Men Who Have Unwanted Same-Sex Attraction." The authors are Santero, S-A-N-T-E-R-O, Whitehead and Ballesteros, Spelled B-A-L-L-E-S-T-E-R-O-S, which I probably butchered. I apologize to them.

MR. MIHET: I think it's Ballesteros.

MS. FAHEY: Oh, okay.

BY MS. FAHEY:

Q So this -- when was the first time you reviewed this study? I see it came out in 2018.

A Yeah, it just came out. I think it was last month I reviewed it. I saw it when it came out.

Q And this study was on adults, correct?

A Right. Yes.

Q And this study did have some reports of harm; is that correct?

A Not any significant reports. It said -- let's see. I think in the conclusion section you'll see what they said about that, but nothing significant they said.

Q Let's turn to PL Joint 777.

A Here's the statement: "Degree of harm is zero to slight."

Q Okay. Could you please turn with me to --

A Yes.

Q -- PL Joint 777.

A Yes.

Q And I'm going to be looking at Table 7. And at the top, Table 7 says "Sexual Orientation Change Effort Effects on Help and Harm for Six Self-reported Mental Health Issues." And the issues that appear right underneath that say "Harm/Help," and that's the scale of whether it was harmful or helpful. Then we go over one and here are the six self-reported issues: "Self-Esteem, Social Functioning, Depression, Self-harm, Suicidality, and Substance Abuse," right?

A Okay.

Q Okay. And so if we look under "Depression," can you find that on the --

A Yes.

Q And so "Depression," zero people reported extremely negative responses, right?

A Uh-huh. Uh-huh.

Q We have three people reporting markedly negative responses?

A Uh-huh.

Q Okay. And under that we have three people reporting moderately negative responses?

A Uh-huh.

Q All right. Let's move over to the category "Self-harm."

A Uh-huh.

Q You got that? So we do have one person who reports an extremely negative report here in the self-harm category?

A Uh-huh. Remember, these people come in distressed, so these could be exhibited before they start therapy.

Q Okay.

A I'll explain -- when you're done, I'll explain how to interpret this.

Q Sure. So we've got one person reporting markedly negative effects in the self-harm category, right?

A Uh-huh.

Q Now let's move over to "Suicidality." We've got one person reporting extremely negative effects?

A Uh-huh.

Q We've got another person reporting markedly negative effects?

A Uh-huh.

Q And two people reported in the suicidality category?

A Uh-huh.

Q For "Substance Abuse," we have one person reporting markedly negative effects?

A I'm sorry, where is "Substance Abuse"? Oh, yes, I see it.

Q It's all the way at the end.

A Got it.

Q So one person reported markedly negative effects, and one person reported moderately negative effects, right?

A Uh-huh.

Q Okay. So those were the findings that are reported here in Table 7, and we only looked at some of them, I know that.

A Uh-huh.

Q So I just wanted to make sure we read those correctly.

A Okay. And I want to comment on those, unless you were going to go on in discussing, but I would say I think it's important to read in the "Conclusion," the last paragraph on page PL Joint 781. "Degree of harm is zero to slight and about typical of harm for therapy for other unwanted problems. This therapy is not really exceptional but should be considered in the ranks of the conventional, with conventional safeguards as codified several years ago."

So in therapy for any issue, you would see these types of outcomes is what these researchers are showing. In fact, one of these researchers I know very well and is a very understated person. He understates everything. So, in other words, if there's a positive effect, he's going to err on the side of -- he would never exaggerate it, he would understate it. And if there was a negative effect, he would make it very clear, and you see that reflected in this table and you see that there was one or zero in these categories that you mentioned, but you also see that he's explaining that therapy always will have people who leave dissatisfied, who leave depressed, distressed, or still remaining in their problems that they got into therapy.

You know, when I was at school, they used to loosely say this, I don't know if it's true or not, but they used to say a third of the people that come to therapy are going to feel better, a third are not going to feel any different, and a third are going to feel worse. And like I said, that was just a loose -- I don't know where that ever came from, but the idea is that therapy is not going to make everyone feel 100 percent better 100 percent of the time.

So this has to be taken only along with this statement that he wrote there that that effect --

because I think as we say that and put that on the record, it sounds like people became -- one person became suicidal and one person had -- no, this is zero to slight. This is how it works in therapy. Not everyone leaves 100 percent resolved with their issues. And you would see no difference if it was a study on treatment for depression or treatment for anxiety or any other issues, so let's keep that in the record as we discuss this article.

Q Let's turn now to PL Joint 784. The title of this article is "Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study," and the author is Diamond.

A Uh-huh.

Q Okay. When did you first review this article?

A I received her book, which is called "Sexual Fluidity," and so I received that years ago, maybe when this -- it looks like it may have been the same time. So this particular article, I probably saw the article this week, but the book I had -- I received years ago, so I was familiar with the idea of sexual fluidity.

Q Let's turn to PL Joint 811.

A Is that still in the same article or a different article?

Q I think it's a different article.

A So before we leave this article then, I just want to say this is so interesting because it's talking about bisexuality and just the tenancy for -- especially girls. I think now they're saying even both, but they used to say it was more girls than boys. There was a lot of sexual fluidity and a lot of change would occur.

And so one of the astounding things that colleagues first started -- myself and other colleagues first started noting when these bans began is that we are not even -- under these ordinances, we're not even allowed to treat or help, talk to bisexual clients, and bisexual clients can change either way. They are saying they're attracted to both, but if a bisexual client came in saying they want to increase the heterosexual desire and decrease some of the homosexual desire that they have and they want to explore the issues underlying that to see if it would at all be possible for those attractions to change, under this ordinance we would even have to tell them no and they're not even -- the ones that I think the framers of these ordinances -- drafters of these ordinances had in mind, the ones that they think are just kind of fixed in their state, which it's not a fixed state anyway, but with the bisexual clients, it's clear that they have attractions both ways, but we can't even help them to look for a shift or

a change even in their behavior.

So it's just -- this kind of article I think speaks loudly to the, uh-uh, no offense, but the ludicrous nature of the ordinances.

Okay. So we want to go to 8 --

Q -- 11.

A Okay.

Q Okay. The title of this one is "A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder." The authors are Zucker, Z-U-C-K-E-R, Wood, Singh, S-I-N-G-H, and Bradley.

Do you recall when the first time you reviewed this article was?

A Probably this week, but I have been familiar with Zucker for a very long time and the success that he has in working with gender -- back then it was gender identity disorder with children. They don't refer to them anymore, but he was very successful in change and helping them to change their identity.

Q If you will turn with me to PL Joint 833, that's one of the pages of this article. I am referring to the first big paragraph. There's little paragraphs at the top, but there is a line in the middle of that first full paragraph that begins "In our own clinic we

have never" -- do you see that?

A Yes.

Q Okay. "In our own clinic we have never advocated for the prevention of homosexuality as a treatment goal for GID in children."

A Right.

Q Were you aware that that was this person's theoretical orientation?

A Yes, I was.

Q Would you share that theoretical orientation that you have never advocated for the prevention of homosexuality as a treatment goal for GID, which I know is an outdated term, to gender dysphoria in children?

MR. MIHET: Form.

THE WITNESS: I would have to think about whether I would make that statement or not personally, but I think he was just trying to say that he was helping the children to not be distressed and confused anymore. And I think --

From what I recall, he was trying -- I think people had accused him of trying to prevent homosexuality and he wanted to be sure that he wasn't painted -- he was not a -- from what I remember, he was not a religiously motivated person or anything. He wanted to be sure not to offend

homosexuals, so I believe that statement was about not wanting to offend homosexuals that were complaining that he was doing this work with children, and ultimately some of them -- it may prevent some of them from becoming homosexual, and I think he was saying that wasn't his intent.

Whether I would make that same statement or not, I would have to think about that some more.

BY MS. FAHEY:

Q Okay. And on the next page 834, I see that in the second full paragraph he discusses the approaches for different children with GID. And in the very last sentence it says, "But if the clinical consensus is that a particular adolescent" -- are you with me?

A Uh-huh. Uh-huh.

Q Okay. So "But if the clinical consensus is that a particular adolescent is very much likely to persist down a pathway toward hormonal and sex reassignment surgery, then our therapeutic approach is one that supports this pathway on the grounds that it will lead to a better psychosocial adaptation and quality of life."

A Uh-huh.

Q Is that something that you would do as well?

MR. MIHET: Form.

THE WITNESS: So I would have to think about that. Now we know a lot more about the dangers of those types of drugs for people who submitted that article. I don't know if we would consider that as safe a path, physically safe or emotionally. The suicide rates for transgendered individuals are much higher -- in fact, after surgery, we're talking about those who do pursue the transgender option with surgery, the suicide rates are very high.

So I don't know that I would make that recommendation to be honest with you, but I do want to just say that prior -- right above that sentence he is saying that "From a developmental perspective, we take a very different approach working with adolescents than we do with children," and I would agree with that. That's why I believe we have to help children early because the longer it persists -- some of them just outgrow it naturally, many of them do, a high percentage of them do, but for the ones that it persists, it does become harder to help them with changing their perceptions of themselves the older they get. So that's why these types of ordinances are so dangerous because we're not allowed to intervene

when they're young.

You know, a five year old that's kind of confused about who they are is a lot different than a 16 year old who's a boy that says he's a girl and he's always felt that way since he was three years old. That child -- 18, let's even say 18 because I couldn't help the 16 or 17 year old under these ordinances, but let's say the 18 year old comes in and says, "Yeah, I think I'm a boy and I've always felt like a boy but I'm in a girl's body. I'm trapped in a girl's body." There's a lot less room to help that child -- well, I should say it's going to be a lot harder to help that child, and I think that's what he's saying here too is that treating a young child is a lot easier and a lot more effective. And he's saying his approach shifted when they -- if this is persisting into adolescence, this thing is going to be harder to -- their perceptions are not going to change as easily. And so he's saying that, for some, he would just go ahead and recommend they continue down that path.

I'm not saying I agree with his -- that statement, but I think his statement does speak to the need for us to be legally permitted to

intervene early with these children that are gender confused.

BY MS. FAHEY:

Q So you're saying you cannot say one way or another whether you have an adolescent who has gender dysphoria or -- I know you don't give diagnoses, but is persisting down a path of identifying with a gender that differs from their anatomical sex, you cannot say at this time whether you would do as he does in this 2012 article where he says he would support that pathway because he says it will lead to a better psychosocial adaptation and quality of life? You're not able to tell me one way or another whether you would do that too?

A Research doesn't back-up that it would lead to a better quality of life. There's a higher suicide rate and now we know about adverse health effects, so I -- this is no longer a true statement, this better quality of life, but also I would --

The way it works for me is the ones that are coming to me that are transgender in the teen years usually have parents who are not permitting that -- are not permitting them to identify as the opposite sex. So if it was a family who wanted to go down that path, I could refer them to a therapist that would assist them in going down that path, but my client -- my clients,

typically the parents aren't wanting that, and so we talk about, "Well, how can you guys agree to disagree while you're under the same roof?" Obviously when the kid is an adult they can go and do what they want, but typically the ones I'm seeing, they're not allowed to do that while they're living at home, so we talk about family relationships.

It wouldn't -- I couldn't encourage a client to go down a transgendered path living under the roof and the home of parents who don't want that for them. I work towards family harmony instead.

Q Dr. Hamilton, thank you very much for your patience with my questions with you today. I know I had to explain myself and do some hypotheticals to better communicate. I appreciate you answering my questions. That is all I have for you.

A Okay. Thank you very much. You did a great job asking that and clarifying that. Thank you.

MR. MIHET: We're not done yet.

THE WITNESS: Oh, we're not done? Okay.

MR. ABBOTT: Not unless you got some questions.

MR. MIHET: Oh, I do have some questions. Since you left ten minutes on the clock, we've got to fill it.

CROSS-EXAMINATION

BY MR. MIHET:

Q Dr. Hamilton, you were shown earlier today what was marked as Defendants' Exhibit 10. Do you recall that?

A Yes.

Q And I believe we established that this is a printout that the county's attorney obtained from your website.

A Yes.

Q Somewhere near the top of this printout there is a statement that says "Providing psychotherapy in Palm Beach Gardens, Florida." And I read that correctly?

A Yes.

Q What did you intend that statement to convey on your website?

A I was just conveying that that's where my office is currently located.

Q Did you intend that statement to convey that you would only provide psychotherapy services in Palm Beach Gardens, Florida?

A No.

Q Do you want to be able to provide psychotherapy services in locations other than Palm

Beach Gardens, Florida?

A Yes, there would be occasions where I would.

Q Earlier in your testimony today you described two clients that you were required to turn away because of the ordinances. Do you recall that testimony?

A Yes.

Q Where do those clients live?

A One of those clients is actually in Broward County and I --

Q Whereabouts in Broward? If you know.

A It's the Fort Lauderdale area or, I'm not sure, Plantation.

Q Okay.

A Yeah, somewhere very south, south Broward.

Q How far, approximately, is Broward County from Palm Beach Gardens, Florida?

A At least an hour it takes them -- it has taken them to get to my office.

Q And is that a long or a short distance for a client to drive to your office?

A Uh-huh. Well, prior to them -- you know, I met with the parents and then I met with the family, but I was no longer -- I was not able to meet with the child. So prior to me saying, "Okay. You know, there's not a whole lot more I can do," they -- it was a

hardship and I would have liked to accommodate, help them. And so if I was permitted to work with the child, I would like to be able to work with them.

I know that there's an office in Boca Raton that a colleague has that I've been -- that's been offered to me that I could use, an office in Boca to meet that family halfway to make it easier for them. If there was -- yeah.

Q Have you already been given permission to use that office --

A Yes, I have.

Q -- to meet with this client?

A Yes, I have.

Q And if the court were to issue an injunction in this case on October 18th of 2018, would there be anything else prohibiting you from meeting with this client for purposes of counseling in the city of Boca Raton on the following day, October 19, 2018?

A No.

Q And would that be your desire and your intention?

A Yes. I would like to be able to meet with them halfway to help -- yes.

Q Why are you not meeting with them today in that office in Boca Raton that has been offered to you

for that purpose?

A Because I'm not allowed to talk to the minor client about gender confusion in Boca Raton.

Q What is stopping you?

A The county ordinance and the Boca Raton city ordinance. Can I add something?

Q Have you given any presentations or talks in the city of Boca Raton?

A I give presentations in a lot of different areas. I have talked -- I think prior to the passage of the county ordinance, I think I had talked to someone at a church in Boca about coming down and doing a talk, and so that's a -- that's still -- we haven't made any arrangements, but that's still a possibility.

If I was to do a talk in Boca, one of the things that I have already thought of -- in anyplace in this county, but I do have a -- someone that I've talked to in Boca, but is that if I was doing a talk publicly about preventing gender identity confusion or parenting regarding this issue, then I would -- a lot of times when I do talks, people come up to me afterwards and they want to talk about their situation; or if I spoke in a church and the parents, you know, wanted to get their child out of childcare and bring them up and say, "Oh, could you talk to my child for a couple of

minutes?" under this ordinance, even outside of the therapy office, I would have to say no.

So in Boca Raton, if I spoke at a church, if I spoke at a school, I do -- by the way, I have spoken in school chapels, so that would be minors. And if anyone in a chapel setting came up to me afterwards and said, "Can I talk to you? I've actually been struggling with this issue that you talked about today in chapel," I would have to say, "I am so sorry, I'm not allowed. You can talk to me, but I can't talk back to you." And so that would be true outside of the therapy office because it says paid or unpaid.

So my freedom of speech is limited. And any time I do a speaking engagement that involves where a minor might either be brought by their parent or might come up to me voluntarily -- and I have had speaking engagements where kids come up to me afterwards and want to talk about their personal problems.

Q Do you have any clients that are located within the city of Boca Raton --

A Yes.

Q -- currently?

A I do.

Q Adult or minor?

A Adult.

Q And how do you provide counseling services to this client that is residing in the city of Boca Raton?

A That's one of my phone therapy sessions that I had talked about earlier. I do have the phone -- this client feels it's too far to drive to Palm Beach Gardens, so we do phone instead of face-to-face.

Q And --

A But I would not do phone therapy with a minor, so I would need to go to Boca. If there was a minor in Boca or a minor in Broward County, I would need to go to Boca to see them. I would not do phone therapy with them. With an adult I would do phone therapy.

Q Do you want to be able to offer your counseling services to residents of the city of Boca Raton?

A Yes. That would be very good not to have my speech restricted in Boca Raton.

Q Including minors?

A Including minors, yes, definitely. Because -- and the other thing, I've said it already today, but this issue is not going away, it's growing. We know that transgender confusion is in -- the children, the number of children experiencing transgender confusion is increasing dramatically, so I anticipate that I will see a lot more clients with this issue if it were legally

permissible.

And I don't know a lot of therapists that do work with gender confused children, and so I would like to be able to see them beyond just Palm Beach Gardens.

Q Why are you not offering your talk therapy counseling services to the residents of the city of Boca Raton today, the minor residents?

A The minors? Because it's -- there's a city ordinance that says I cannot talk to minors about attractions, behaviors, mannerisms, or identity, perceptions of self, gender identity.

Q Any other reason?

A That I'm not able to talk to minors in Boca?

Q Yes.

A The ordinance is the only reason.

Q Okay. That's all I have. Now I think Mr. Abbott will have some questions for you.

CROSS-EXAMINATION

BY MR. ABBOTT:

Q Doctor, what is the name of the client family in Broward County?

A Oh, I can't give that name. HIPAA would restrict me from doing that.

Q You're refusing to answer that question?

A I'm not legally permitted to answer that

question.

Q Is the answer to my question you're refusing to tell me the name of that client family?

A I'm not legally permitted --

MR. MIHET: I'm also instructing her not to give it to you.

BY MR. ABBOTT:

Q What is the name of the colleague who has an office in Boca Raton who has offered you to use that office?

A Dr. Otto.

Q When did Dr. Otto offer to allow you to use his office?

A I believe he offered that shortly after probably -- probably back in January.

Q You met Dr. Otto in connection with the consideration and passages of ordinances that are the subject of this lawsuit, true?

A Yes.

Q So he didn't offer you to use his office at any time prior to the ordinances being adopted?

A Right.

Q When was your conversation with the family that lives in Broward County?

A That was probably March or May, probably

spring, I'm not sure.
Q Of this year?
A Yes.
Q And where did that conversation take place?
A Where did the conversation with the family --
Q Yes.
A They drove up to Palm Beach Gardens but expressed that it was very far.
Q No, ma'am. When was your first --
A Oh, the first conversation?
Q -- conversation with them?
A On the phone. They usually call me for the intake.
Q That was your first contact with the family is when they called you at your office?
A They called me -- yeah, I get messages on my cellphone so I wasn't standing in my office when I checked my messages and returned their call, but my very first contact was they called me -- well, they probably left a message and I probably called them back.
Q Was there any discussion in your first phone communication with that potential client about providing services in Boca Raton?
A At that time I don't think I mentioned it because by the time they called me, it was unlawful for

me to even provide services to their child.

Q So --

A So I said they could come up and I could meet with the parents but I knew that would be limited because at some point, if I can't meet with the child, they're not going to keep coming, so I didn't go to great lengths to meet with them. And at the time that Dr. Otto first offered, he was in the counseling center and there would have been more red tape, so to speak. You know, more steps to take to be able to see people there. Now it's a lot easier because he's in private practice and his office is just a lot more accessible. He doesn't work for anybody else.

So at the time I did not offer because I knew that my work with them would be very brief, and in order for me to work with their child, these laws would have to be changed. These ordinances would have to be changed.

Q Do you have an occupational license or a business tax receipt to practice your profession in Boca Raton?

A No. I used to when I practiced in Boca, but I would renew that if I came down to see clients down there.

Q When did you last have -- when did you last

practice in Boca Raton?

A Yeah. You know, it's interesting. I started out my private -- well, I started with Spanish River and was there until 2002 -- I started with Children's Home Society, but when I was kind of more on my own generating client referrals for myself, that was with Spanish River, and so my client base was Boca Raton. That was -- you know, when I worked for Children's Home Society, the clients came to us. I didn't have to market or try to create -- try to bring -- you know, find clients. But when I first was out sort of on my own but at the counseling center at Spanish River, that was the first time I had to go and try to find clients, so I developed a word-of-mouth referral in the Boca community. That really was my first place seeing clients, you know, again not attached to a nonprofit organization.

And so when I left Spanish River, I just had a lot of word-of-mouth clients in Boca. And even though I didn't live in Boca, it just made the most sense for me to stay in Boca. And so what I did is I expanded to West Palm right away. I went from Spanish River, I went into private practice, and I opened two offices; one was in Boca, one was in West Palm, so that I could expand my client base. And so --

Q During what years did you have an office in private practice in Boca Raton?

A I believe it was 2002 when I left Spanish River, and I believe I kept it -- it was either '04 or '05, but by then I was working full-time teaching at Palm Beach Atlantic and I had the practice in West Palm and the practice in Boca so I had to get rid of something, so I stopped Boca and continued West Palm.

Q Did you continue to obtain business tax receipts or occupational licenses to practice in Boca Raton?

A Once I stopped seeing clients in Boca, I never renew -- I did not renew my occupational license.

Q So you didn't have an occupational license in 2006?

A In 2006? Probably not. If I stopped -- I just remember when I was working at Palm Beach Atlantic it became too much to juggle two offices. I don't know if it was -- I think it was '04 or '05, so I'm going to guess I wouldn't have had it in '06, but I don't know.

Q Or '07?

A Probably not.

Q Or '08?

A Probably not.

Q Or in the ten years since then?

A Right.
Q You have not practiced any services in Boca Raton?
A Right. Because --
MR. MIHET: Form.
BY MR. ABBOTT:
Q And you have not kept your license to -- in order to provide services in Boca Raton?
A Right. Because what happened when I left Palm Beach Atlantic, I had children and so my practice became very limited, it was one day a week, and by then it was Palm Beach Gardens. And so I have not had the priority of expanding my practice; however, as this gender identity issue becomes more of a concern in our culture, I am --
As you saw earlier, I have a passion for this issue, and so I do see the need to eventually expand when the time permits. And I would accommodate this one Broward County family and I don't -- I don't know beyond that if I would expand to two locations, three locations. I don't know what I would do, but I think we need to meet the need of gender identity confusion.
Q The family in Boca Raton, you told us you have provided counseling services for the family?
A It's an individual, it's phone therapy, and

that dates back to my -- you know, the contact was from back then. I still have people that will call me from those days of working in Boca.

Q The therapy has only been done by phone?

A Since I've been not in Boca. In Boca it was face-to-face with that client.

Q With the family in Broward County --

A Which one?

Q -- that we've been talking about.

A Oh, I thought you said the phone therapy. I'm sorry, I got confused.

MR. MIHET: I believe you said the family in Boca. That's what confused her.

MR. ABBOTT: Oh, forgive me. I'm sorry.

THE WITNESS: Yeah, you did.

MR. ABBOTT: I'm sorry. Strike that, I misspoke.

THE WITNESS: Okay.

BY MR. ABBOTT:

Q I'm talking about the family in Broward County. You have provided counseling services for some members of that family?

A That family, yeah. Those were the ones I said they came up. The parents came one or two times and then the whole entire family came one time, and I can't

continue because we couldn't talk about the minor's confusion.

Q I remember. So you had about three appointments?

A I think so, yes.

Q And were those in your offices in Palm Beach County -- I mean in Palm Beach Gardens?

A Yes, they were.

Q Did you mention at any time for those three meetings, "Hey, I can meet you in Boca Raton instead because that will save you some travel"?

A No, because I was prohibited by the ordinance to continue working with them.

Q No, ma'am. The three meetings that you provided counseling in Palm Beach Gardens --

A Yeah.

Q -- when you were meeting with that family --

A Yes.

Q -- did you tell them, "Hey, I can provide services for you in Boca Raton because that's closer"?

MR. MIHET: Objection. Asked and answered.

THE WITNESS: I was not -- I knew we would not be continuing services past a few sessions, and so I did not go to the lengths of making arrangements. And at that -- no, I did not make arrangements with

them to meet with them in Boca because it was not going to be an ongoing therapeutic relationship. It was very short-term because I wasn't allowed to talk to that child any further than meeting with the parents.

So I did -- to go to Boca, I would have to begin to make arrangements to work that out in my schedule and to get the occupational license and jump through those hoops, so I would do that if there was a relief from this ordinance. I would talk to the family about that if there was a relief from this ordinance.

BY MR. ABBOTT:

Q Did you discuss with that family the possibility of continuing to provide treatment for them in Boca Raton?

A No. I didn't want to give them false hope that I could work with them beyond what the ordinance restricted me.

Q Thanks, doctor. I don't have any other questions for you.

A Okay.

MR. MIHET: All right. She'll read and sign.

(Whereupon, the deposition was concluded at 5:46 o'clock p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF PALM BEACH)

I, ANGELA CONNOLLY, Registered Professional Reporter, Notary Public, State of Florida, certify that JULIE H. HAMILTON, PH.D., LMFT, personally appeared before me and was duly sworn on the 30th day of August, 2018.

Signed this 5th day of September, 2018.

ANGELA CONNOLLY
MY COMMISSION # GG 115980
EXPIRES: August 21, 2021
Bonded Thru Notary Public Underwriters

Angela Connolly

Angela Connolly, R.P.R.
Notary Public, State of Florida

Personally known _____
Produced identification FL DL

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF PALM BEACH)

I, ANGELA CONNOLLY, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of JULIE H. HAMILTON, PH.D., LMFT; that a review of the transcript was requested; and that the foregoing transcript, Pages 1 through 344, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

The certification does not apply to any reproduction of the same by any means unless under the direct control and/or direction of the reporter.

DATED this 5th day of September, 2018.

Angela Connolly

Angela Connolly, R.P.R.

HORATIO G. MIHET, ESQ.
LIBERTY COUNSEL
P.O. BOX 540774
Orlando, FL 32854

DATE: September 5, 2018

In Re: Robert W. Otto, Ph.D., LMFT, and Julie H. Hamilton, Ph.D., LMFT vs. City of Boca Raton, Florida, and County of Palm Beach, Florida

Dear Mr. Mihet:

This letter is to inform you that the deposition of JULIE H. HAMILTON, PH.D., LMFT, taken on August 30, 2018 in the above-captioned matter has been completed and is ready for her to read and sign.

The transcript is being held in my office. Please make arrangements with my office so she can read and sign her deposition.

Thank you for your prompt attention to this matter.

Cordially yours,

Angela Connolly

Angela Connolly
Registered Professional Reporter

cc: Rachel Fahey, Esq.
Daniel Abbott, Esq.

ERRATA SHEET

Robert W. Otto, Ph.D., LMFT, and Julie H. Hamilton, Ph.D., LMFT vs. City of Boca Raton, Florida, and County of Palm Beach, Florida
Case No. 9:18-CV-80771
Taken: August 30, 2018

DO NOT WRITE ON TRANSCRIPT - - ENTER CHANGES HERE:

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Under penalties of perjury, I declare that I have read my foregoing transcript and, together with any changes made above, the facts stated herein are true.

_____ _____
JULIE H. HAMILTON, PH.D., LMFT Date