IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, *Plaintiff*, v. LAWRENCE J. HOGAN, JR., *et al*., *Defendants*.	Civil Action No. 1:19-CV-00190-DKC

MOTION OF FREESTATE JUSTICE, INC. FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS

Pursuant to this Court's Standing Order 2018-07, proposed *amicus curiae* FreeState Justice, Inc. ("FreeState") respectfully seeks leave to file the attached *amicus* brief in support of Defendants' Motion to Dismiss (Dkt. 26) and Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction (Dkt. 25).

District courts have broad discretion whether to grant or deny motions for leave to appear as amicus curiae. *Am. Humanist Ass'n v. Maryland-Nat'l Capital Park & Planning Comm'n*, 303 F.R.D. 266, 269 (D. Md. 2014). "The aid of *amici curiae* has been allowed at the trial level where they provide helpful analysis of the law, they have a special interest in the subject matter of the suit, or existing counsel is in need of assistance." *Bryant v. Better Bus. Bureau of Greater Maryland, Inc.*, 923 F. Supp. 720, 728 (D. Md. 1996).

FreeState Justice, Inc. is Maryland's statewide advocacy non-profit that seeks to improve the lives of lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people in Maryland. As a legal advocacy organization, FreeState Justice seeks to improve the lives of low-income LGBTQ Marylanders by combining direct legal services with education and outreach to ensure that the

LGBTQ community in Maryland receives fair treatment in the law and society. In keeping with its mission, FreeState Justice played an integral role in advocating for the passage and subsequent enactment in 2018 of Maryland's Youth Mental Health Protection Act, Md. Code. Ann., Health Occ. § 1-212.1, which prohibits mental health or child care practitioners from engaging in so-called "conversion therapy" with any individual who is a minor. Indeed, the community FreeState Justice serves includes some of the very Maryland residents who are most in need of the protections the Section 1-212.1 provides, including LGBTQ children at risk of being subjected to conversion therapy and their parents. Therefore, FreeState Justice not only has "demonstrated a special interest in the outcome of the suit," *Am. Humanist Ass'n*, 303 F.R.D. at 269, but it "represent[s] large constituencies of individuals which have a vested interest" in validity of Maryland's Youth Mental Health Protection Act. *Bryant*, 923 F. Supp. at 728.

Indeed, organizations such as FreeState Justice have been permitted to intervene as parties or serve as *amicus* in similar lawsuits because they provide "a helpful, alternative viewpoint from the vantage of some persons who have undergone [conversion therapy] or are potential patients of treatment that will aid the court in resolving plaintiffs' claims fully and fairly." *King v. Christie*, 981 F. Supp. 2d 296, 310 (D.N.J. 2013) (quoting *Pickup v. Brown*, 2:12-cv-02497, 2012 WL 6024387, at *4 (E.D. Cal. Dec. 4, 2012) (quotation marks omitted)) (permitting intervention by statewide LGBTQ rights advocacy organization to defend conversion therapy ban), *aff'd*, 767 F.3d 216, 246 (3d Cir. 2014); *see also* Order, *Otto v. City of Boca Raton, Fla.*, Case No. 9:18-cv-80771-RLR (S.D. Fla. Sept. 4, 2018) (Dkt. 73) (granting motion of statewide LGBTQ rights advocacy organization to participate as *amicus curiae* in order to defend conversion therapy ban); Order, *Vazzo v. City of Tampa, Fla.*, Case No. (M.D. Fla. Apr. 4, 2018) (Dkt. 60) (authorizing statewide

LGBTQ rights advocacy organization to participate as *amicus curiae* in order to defend conversion therapy ban).

The brief presented by proposed *amicus* FreeState Justice would "not delay the proceedings or the issuance of a final ruling," but rather "provide[] helpful information to the court." *Washington Gas Light Co. v. Prince George's Cty. Council*, No. CIV.A. DKC 08-0967, 2012 WL 832756, at *3 (D. Md. Mar. 9, 2012). Specifically, the proposed *amicus* brief would provide the Court with context about how efforts to change a person's sexual orientation or gender identity are ineffective, unethical, and unsafe, as well as the consensus of the nation's leading medical and mental health organizations opposing to such "therapeutic" efforts. Proposed *amicus* would further provide the Court with legal analysis about how Maryland's Youth Mental Health Protection Act survives First Amendment scrutiny, because it regulates only the use of a particular procedure for mental health treatment in order to protect patient health and safety. *Nat'l Inst. of Family and Life Advocates ("NIFLA") v. Becerra*, 138 S. Ct. 2361, 2374 (2018). Thus, FreeState Justice's participation as *amicus curiae* would "be useful in resolving the issues presented by the parties." *Bryant*, 923 F. Supp. at 728.

Finally, in accordance with Standing Order 2018-07, para. 2(d) and (e), counsel for proposed *amicus* FreeState Justice certifies that no counsel for a party authored the attached *amicus* brief, in whole or in part, and no person other than *amicus curiae* and their counsel made any monetary contribution to fund the preparation or submission of the attached brief.

For the foregoing reasons, we respectfully request the Court's permission to file an amicus brief in the aforementioned matter.

March 15, 2019

Respectfully submitted,

/s/

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CERTIFICATE OF COMPLIANCE

The undersigned counsel hereby certifies that the attached brief is no longer than 15 pages and otherwise complies with Local Rules 102.2 (format of court documents), 105.1(a) (electronic filing), 105.4 (table of contents, when required), and 105.5 (appendix, when required).

/s/
Jennifer Kent

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BRIEF OF *AMICUS CURIAE* FREESTATE JUSTICE, INC. IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS AND DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Amicus curiae FreeState Justice, Inc., hereby submits this Brief in Support of Defendants' Motion to Dismiss and Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction.

BACKGROUND

Maryland's Youth Mental Health Protection Act, codified as Md. Code. Ann., Health Occ. § 1-212.1 (hereinafter, "Section 1-212.1"), is based on the consensus of the nation's leading medical and mental health organizations that efforts to change a person's sexual orientation or gender identity are ineffective, unethical, and unsafe. In 2009, the American Psychological Association surveyed then-existing scientific literature in a report entitled "Appropriate Therapeutic Responses to Sexual Orientation." *See* Am. Psychological Ass'n, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (Aug. 5, 2009), *available at* https://perma.cc/KX75-3KW4 (hereinafter, "APA Report"). The APA Report concluded that "sexual orientation change efforts" (SOCE) are not only ineffective, but put patients—and especially minors—at risk of serious long-term harms. The APA's conclusions included the following:

- **The APA Report recognized that "conversion therapy" is another commonly used term for SOCE:** "[W]e use the term sexual orientation change efforts (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex[.]" APA Report at 2 n.**; *id.* at 93-117 (citing numerous studies and references concerning "conversion therapy").[1]

- **The APA Report found that conversion therapy for minors is ineffective:** "We found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation." APA Report at 79.

- **The APA Report concluded that the available research demonstrated evidence of harm from conversion therapy:** "[S]cientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants." APA Report at 83.

- **The APA Report cited recent studies documenting harm from "non-aversive" techniques:** With respect to recent studies, "the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction." APA Report at 42.

- **The APA Report concluded that licensed mental health providers <u>should not engage in sexual orientation change efforts with minors under any circumstances</u>, <u>regardless of whether techniques are aversive or non-aversive, and including for "children and adolescents who present a desire to change their sexual orientation"</u>**: "We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families *rather than SOCE*. . . . These approaches would support children and youth in identity exploration and development *without seeking predetermined outcomes*." APA Report at 79-80 (emphasis added).

- **The APA Report concluded that conversion therapy offers no unique benefits.** "The positive experiences clients report in SOCE are not unique, and "the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation." APA Report at 68; *see also id*. at 53 (same).

- **The APA Report concluded that conversion therapy could not be justified by invoking client autonomy or self-determination.** "We believe that simply providing

[1] Although Plaintiff refers to conversion therapy as a "political" term, Dkt. 2 at 6, it is in fact one of several terms, which also include "reparative" or "reorientation" therapy, commonly used in the relevant research literature and by the country's leading medical and mental health organizations to refer to therapeutic attempts to change sexual orientation or gender identity. All of these terms appear in the statements of medical and mental health organization relied on by the legislature in enacting § 1-212.1. *See* Dkt. 25-3.

> SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of LMHP [licensed mental health professionals] to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm." APA Report at 70.

In 2015, the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services conducted an updated survey of existing research on conversion therapy and published a report and recommendations based on "consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance." Substance Abuse and Mental Health Serv. Admin., U.S. Dep't of Health and Human Serv., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Oct. 2015), at 1, *available at* https://perma.cc/KAC4-BHXD (hereinafter, "SAMHSA Report"). The report found "none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation." *Id*. It concluded: "Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment." *Id*.

Other medical and mental health organizations that have reached similar conclusions include: the American Medical Association, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Physicians, American Association for Marriage and Family Therapy, National Association of Social Workers, American Psychoanalytic Association, American Counseling Association, American School Counselor Association, American School Health Association, American Academy of Nursing, American Osteopathic Association, Pan American Health Organization, and World Psychiatric Association. *See* Nat'l Ctr. For Lesbian Rights, *Born Perfect:*

Toolkits, Resources & Statements, *available at* http://www.nclrights.org/bornperfect-toolkit-resources-statement/ (collecting statements) (last accessed Mar. 14, 2019).

Subsequent research has only further strengthened these conclusions. A recent peer-reviewed study found that lesbian, gay, bisexual and transgender (LGBT) adolescents subjected to conversion therapy were *nearly three times more likely to attempt suicide and experience serious depression* than other LGBT youth. *See* Caitlin Ryan et al, *Parent-Initiated Sexual Orientation Change Efforts with LGB Adolescents: Implications for Young Adult Mental Health and Adjustment*, Journal of Homosexuality (2018) (attached as Exhibit 1).

The National Institutes of Health list suicide as the second leading cause of death for youth between the ages of 10 and 24. *See* Nat'l Inst. of Mental Health, *Suicide*, *available at* https://www.nimh.nih.gov/health/statistics/suicide.shtml (last accessed Mar. 14, 2019). According to a 2018 survey of existing research, sexual minority youth are more than three times more likely to have attempted suicide than heterosexual youth. *See* Ester de Giacomo et al., *Estimating the Risk of Attempted Suicide Among Sexual Minority Youths: A Systematic Review and Meta-Analysis*, *JAMA Pediatrics* (Dec. 2018), at E3, *available at* https://perma.cc/53Y3-B4LS.

In light of this evidence, Maryland has a compelling interest in protecting youth from a discredited medical treatment that increases the rate of attempted suicide by three times among a population that already is at a dangerously high risk of suicidality.

ARGUMENT

I. SECTION 1-212.1 DOES NOT VIOLATE THE FIRST AMENDMENT'S SPEECH CLAUSE.

Under Supreme Court and Fourth Circuit precedent, Section 1-212.1 is subject to rational basis review, like other regulations of health care treatments that incidentally impact speech while protecting the public from harmful practices. Here, the harms caused by conversion therapy are so

great, the medical consensus recognizing those harms is so strong, and the statute is so narrowly-tailored to protect minors from those harms, that it would survive not only rational basis review, but any level of review.

A. *NIFLA* Confirms That States May Regulate Medical Treatment To Protect Public Health and Safety, Just As Section 1-212.1 Does Here.

In *National Institute of Family and Life Advocates ("NIFLA") v. Becerra*, 138 S. Ct. 2361, 2373 (2018), the Supreme Court invalidated a California law requiring licensed pregnancy clinics to notify women that California provides free or low-cost services including abortion, and requiring unlicensed clinics to notify women that California has not licensed them to provide medical services. 138 S. Ct. at 2368. In doing so, the Court expressly reaffirmed the settled proposition that governments may protect patients from harm by regulating medical *treatments* provided by licensed health care practitioners: "[t]he First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech . . . and professionals are no exception to this rule." *Id.* at 2373. *NIFLA* confirmed that states may regulate medical practice to protect patients from harm, even when doing so restricts some speech that is "part of the practice of medicine." *Id.* at 2373.

The Court explained that California's law triggered heightened scrutiny because its required disclosures were "not tied to a [medical] procedure" and instead "applie[d] to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed." The law therefore directly regulated speech as such and improperly "compel[led] individuals to speak a particular message." *Id*. at 2371.

The Court contrasted these untethered speech requirements with the informed consent requirement upheld in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 884 (1992), which "regulated speech only as part of the *practice* of medicine." *NIFLA*, 138 S. Ct. at

2373 (emphasis in original). Here, like the regulation in *Casey*, the Maryland law is limited to a specific treatment—the practice by licensed therapists of conversion therapy for minors, a dangerous and discredited mental health treatment. The statute is extremely narrow, applying only to the actual provision of that discredited treatment, and exempts all speech between therapists and their clients that is not part of the provision of that specific treatment.

For this reason, Section 1-212.1 is subject only to rational basis review, which it plainly survives in light of the strong professional consensus of leading national medical and mental health organizations that conversion therapy for minors is ineffective and puts minor patients at risk of serious harm, including depression and suicidality. In contrast, there was no such medically-based justification for the disclosure requirements at issue in *NIFLA*, which were "not tied to a procedure at all." 138 S. Ct. at 2373.

B. Section 1-212.1 Is Permissible Under The First Amendment As A Reasonable Regulation Of A Particular Mental Health Treatment.

Laws enacted pursuant to a state or locality's police power generally are entitled to "a presumption of legislative validity." *Kelley v. Johnson*, 425 U.S. 238, 247 (1976). "A statute that governs the practice of an occupation is not unconstitutional as an abridgment of the right to free speech, so long as 'any inhibition of that right is merely the incidental effect of observing an otherwise legitimate regulation.'" *Accountants' Soc'y of Va. v. Bowman,* 860 F.2d 602, 604 (4th Cir. 1988) (quoting *Underhill Assoc. v. Bradshaw*, 674 F.2d 293, 296 (4th Cir. 1982)) (upholding statute prohibiting unlicensed accountants from using terms such as "generally accepted accounting standards" in financial reports).

To be sure, regulations of medical professionals may implicate the First Amendment "when the government tries to control public discourse through the regulation of a profession," such as by limiting "public discussion and commentary." *Nat'l Ass'n for Advancement of*

Multijurisdiction Prac. v. Lynch, 826 F.3d 191, 196 (4th Cir. 2016) (citation and internal quotation marks omitted). "When the First Amendment rights of a professional are at stake, the stringency of review thus slides 'along a continuum' from 'public dialogue' on one end to 'regulation of professional *conduct*' on the other." *Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2014) (quoting *Pickup v. Brown*, 740 F.3d 1208, 1227, 1229 (9th Cir. 2013)) (emphasis in original). "Because the state has a strong interest in supervising the ethics and competence of those professions to which it lends its imprimatur, this sliding-scale review applies to traditional occupations, such as medicine or accounting, which are subject to comprehensive state licensing, accreditation, or disciplinary schemes." *Greater Baltimore Ctr. for Pregnancy Concerns, Inc. v. Mayor & City Council of Baltimore*, 879 F.3d 101, 109 (4th Cir. 2018). "Quite simply, '[t]here is a difference, for First Amendment purposes, between regulating professionals' speech to the public at large versus their direct, personalized speech with clients.'" *Otto v. City of Boca Raton*, 353 F. Supp. 3d 1237, 2019 WL 588645, at *13 (S.D. Fla. 2019) (quoting *Locke v. Shore*, 634 F.3d 1185, 1191 (11th Cir. 2011). Thus, "[t]he speech of medical providers is routinely limited through prescription drug laws, medical malpractice lawsuits, accreditation requirements, and other means." *Id.*

Like the Supreme Court in *NIFLA*, the Fourth Circuit has recognized the critical "distinction between professional speech and professional conduct when deciding on the appropriate level of scrutiny to apply to regulations of the medical profession." *Stuart*, 774 F.3d at 248. In *Stuart*, for example, the court struck down a law that required physicians to perform an ultrasound while displaying the resulting images and describing the fetus to women seeking abortions. The court concluded that on the "continuum" of professional regulations, such a law must be regarded as an instance of content-based compelled speech requiring at least intermediate scrutiny. *Id.* at 245. In so concluding, the court emphasized the "extraordinary" nature of the

compelled disclosures, which were "intended to convey not the risks and benefits of the medical procedure to the patient's own health, but rather the full weight of the state's moral condemnation" of the patient's decision to seek abortion. *Id.* at 254, 255. The compelled disclosures were not related to patient health and safety, but were entirely "ideological": "[t]he state freely admit[ted] that the purpose and anticipated effect . . . [was] to convince women seeking abortions to change their minds or reassess their decisions." *Id.* at 246. "[F]ar from promoting the psychological health of women," this compelled speech "risk[ed] the infliction of psychological harm" on women. *Id.* at 253.

Section 1-212.1 is unlike the law invalidated in *Stuart*. As two federal courts of appeals have recognized in upholding laws similar to Section 1-212.1, the purpose of legislation protecting minors from the discredited practice of conversion therapy is entirely based on the need to protect the health and well-being of minors and firmly grounded in the broad professional consensus that conversion therapy is ineffective, harmful, and unethical. These laws' sole purpose and effect is to prevent minor patients from being subjected to an unsafe treatment, not to restrict therapists' speech or compel communication of the government's preferred message. *See Pickup*, 740 F.3d at 1230 ("Because SB 1172 regulates only treatment, while leaving mental health providers free to discuss and recommend, or recommend against, [conversion therapy], we conclude that any effect it may have on free speech interests is merely incidental"); *King v. Governor of N.J.*, 767 F.3d 216, 237 (3d Cir. 2014) ("The New Jersey legislature has targeted [conversion therapy] counseling for prohibition because it was presented with evidence that this particular form of counseling is ineffective and potentially harmful to clients."); *see also Otto*, 2019 WL 588645, at *15 (concluding that conversion therapy ordinance was closer to the regulations upheld in *Casey* than those invalidated in *NIFLA*).

Like the conversion therapy laws in California, New Jersey, and the City of Boca Raton, Florida, all of which federal courts have upheld, Section 1-212.1 does not compel any speech or prevent therapists from expressing their opinion on any topic. Section 1-212.1 only prevents licensed therapists from subjecting minor patients to a specific course of medical treatment that has been overwhelmingly rejected by the medical community as dangerous and ineffective for minors. "The public marketplace of ideas is not limited in any way. What *is* limited, is the therapy (delivered through speech and/or conduct) by a licensed practitioner to his or her minor patient, within the confines of a therapeutic relationship." *Otto*, 2019 WL 588645, at *16.

Rational basis review thus applies here because, like the challenged regulation in *Casey*, which "regulated speech only as part of the *practice* of medicine," *NIFLA*, 138 S. Ct. at 2373, Section 1-212.1 prohibits only the *practice* of conversion therapy. To the extent speech is implicated at all, it is only because in mental health therapy, speech ordinarily is "the *manner* of delivering the treatment. [Therapists] are essentially writing a prescription for a treatment that will be carried out verbally." *Otto*, 2019 WL 588645, at *15 (emphasis in original). In imposing that restriction on the conduct of licensed therapists, Section 1-212.1 exempts speech between therapists and their clients that is not part of the provision of that specific treatment to minors. The statute does not prohibit mental health professionals from publicly or privately stating a belief in the efficacy or propriety of conversion therapy for minors or adults, or from publicly or privately stating religious or other beliefs about LGBT people. It does not require mental health professionals to make any affirmative statements at all, whether about conversion therapy or any other subject. And it does not apply to the conduct of individuals not operating under a state license.

For these reasons, under both Supreme Court and Fourth Circuit precedent, Section 1-212.1 is subject only to rational basis review, which it easily survives.

C. Plaintiff's Theory Would Call Into Question The Validity Of Numerous Well-Established Regulations of Mental Health Professionals As Content-Based Speech Restrictions.

The sweeping, categorical approach proposed by Plaintiff would gut the well-established governmental authority to regulate licensed practitioners in order to protect public health and safety. Taken to its logical end, this approach would mean that virtually *any* regulation of professional counseling must withstand strict scrutiny, since virtually all such counseling consists largely of speech. That approach would jeopardize many important existing regulations. For example, current Maryland regulations prohibit licensed therapists from:

- representing to the public that they possess a license or certification to practice a type of counseling or therapy that they do not possess, Md. Code Ann., Health Occ. § 17-601, 17-603;
- practicing outside "the boundaries of a counselor's competence, based on education, training, supervised experience, and professional credentials," Md. Code Regs. § 10.58.03.03(A)(1);
- failing to obtain "written authorization to provide counseling services for minors or other clients unable to give informed consent," *Id.* §10.58.03.04(A)(5);
- entering into "relationships that could compromise a counselor's objectivity or create a conflict of interest," *Id.* § 10.58.03.04(B)(3);
- failing to "[i]nform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed," *Id.* § 10.58.03.05(A)(1)(a);
- "[f]oster[ing] dependent counseling relationships," *Id.* § 10.58.03.05(A)(2)(d);
- failing to "[m]aintain the privacy and confidentiality of a client and a client's records," *Id.* § 10.58.03.08(A)(1); or
- "represent[ing] to a client or individual in close personal contact with a client that sexual contact or activity by or with a counselor is consistent with or part of a client's therapy," *Id.* § 10.58.03.09 (F)(2).

Under Plaintiff's approach, all of these requirements would be subject to strict scrutiny. But no court has held that any professional regulation of counselors that may incidentally restrict the speech that occurs within the counseling relationship automatically triggers heightened scrutiny. To the contrary, courts routinely view such regulations as a legitimate exercise of the state's police power to protect health and safety.

Indeed, because licensed mental health professionals use speech as their medical treatment, under Plaintiff's logic, they could not be required to adhere to any professional standards of ethics or care in performing any such treatment, unless those standards could survive strict scrutiny. That is not, and cannot be, the law. *See Otto*, 2019 WL 588645, at *25-26.

D. Section 1-212.1 Also Satisfies Heightened Scrutiny.

Section 1-212.1 also would survive even heightened scrutiny because it is "justified by a compelling interest and is narrowly drawn to serve that interest." *Brown v. Ent. Merch. Ass'n*, 564 U.S. 786, 799 (2011).

1. Maryland Has A Compelling Interest In Protecting Children From Harm.

Maryland enacted Section 1-212.1 to carry out its "compelling interest in protecting the physical and psychological well-being of minors." Dkt. 25-3 at 4. Governments have a compelling interest in the health and well-being of their citizens. *See Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975); *Watson v. Md.*, 218 U.S. 173, 176 (1910).

Furthermore, "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Mass.*, 321 U.S. 158, 168 (1944). Consequently, the Supreme Court "ha[s] sustained legislation aimed at protecting the physical and emotional well-being of youth even when the laws have

operated in the sensitive area of constitutionality protected rights." *N.Y. v. Ferber*, 458 U.S. 747, 757 (1982). That interest is unquestionably served here, where the government seeks to protect minors who are "especially vulnerable to [the] practices" barred by the Section 1-212.1. *King*, 767 F.3d at 238.

In enacting Section 1.212.1, the legislature relied on a broad professional consensus that conversion therapy poses real dangers to Maryland's children. The detailed legislative findings summarize relevant research and the conclusions of well-known, reputable professional and scientific organizations that conversion therapy is highly correlated with depression, suicidality, substance abuse, and other serious harms. *See* Dkt. 25-3. As discussed above, subsequent research and clinical experience have corroborated these risks for children.

Plaintiff complains that the research showing the harms of conversion therapy is not absolutely conclusive. But the First Amendment does not require the government to delay action to protect children from serious threats of harm until it possesses conclusive scientific proof, particularly when acquiring such proof would produce the very harm the government seeks to avoid. *See FCC v. Fox Television Stations*, 556 U.S. 502, 519 (2009). Significantly, responsible professionals stopped conducting double-blind studies on conversion therapy precisely because it was harmful, particularly to minors, and therefore would be unethical to attempt. *See* APA Report at 91; *Otto,* 2019 WL 588645, at *18 & n.12.

2. Section 1-212.1 Is Narrowly Tailored To Advance The State's Compelling Interest.

Plaintiff contends that there are less restrictive alternatives to protect the mental health and well-being of Maryland youth than a prohibition of conversion therapy for minors. But because there are inherent, potentially deadly, dangers whenever a licensed professional attempts to reach the fixed outcome of changing a minor's sexual orientation or gender identity, there are no practical

alternatives to a prohibition on licensed mental health professionals performing such so-called therapy on minors. The "less restrictive alternatives" Plaintiff proposes would still allow minors to be exposed to the very physical and mental harms that are the subject of the medical literature cited by the legislature and that Section 1-212.1 seeks to prevent. *See Otto*, 2019 WL 588645, at *23-24.

First, there is no way for the statute to prohibit only "coercive" and "involuntary" conversion therapy for minors. Conversion therapy is *inherently* coercive because it does not accommodate as a successful outcome any result other than conversion of the patient's sexual orientation or gender identity. And it is inherently involuntary for minors, who have no legal power or practical ability to refuse these efforts if their parents want them to be subjected to it.

As explained by the United States Department of Health and Human Services, the "Professional Consensus on Conversion Therapy with Minors" is that: "*Interventions aimed at a fixed outcome*, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation *are coercive*, can be harmful, and should not be part of behavioral health treatments." SAMHSA Report at 11 (emphasis added). Simply put, the very nature of this therapy—because its goal is a fixed and predetermined outcome—makes it coercive for minors.

Moreover, Maryland law generally does not allow children under the age of 18 to consent to their own medical treatment, leaving all such decisions in the hands of their parents. *See* Md. Code. Ann., Health-Gen. § 20-102. Although Maryland law permits minors aged 16 years or older to consent to treatment of a "mental or emotional disorder," being gay, lesbian, or bisexual is not a disorder, and in any event, minors over 16 are not permitted to refuse treatment for which a parent, guardian, or custodian has given consent. *Id.* § 20-104(b). Given this reality, limiting the

statute to instances of "involuntary" conversion therapy would be meaningless; virtually all such therapy is involuntary where minors are concerned, as a matter of law.

In sum, Maryland law provides no avenue by which minors of any age can effectively refuse or resist conversion therapy treatments wanted by their parents or other adult authorities. Indeed, in rejecting this form of treatment as unethical and unprofessional, professional organizations have recognized that any purported distinction between voluntary and involuntary treatment is meaningless in practice for minors. Minors are under the legal control of parents or guardians and thus cannot themselves decide to legally consent to, or refuse, medical care that could be dangerous to them and that provides no potential benefits. *See also Otto,* 2019 WL 588645, at *23.

For essentially the same reasons, the proposal that minors give "informed consent" before undergoing conversion therapy is not an acceptable alternative. As the Third Circuit noted in rejecting a similar argument, "[m]inors constitute an 'especially vulnerable population,' and may feel pressured to receive [conversion therapy] counseling by their families and their communities despite their fear of being harmed." *King*, 767 F.3d at 240 (quoting APA Report at 121); *see also* APA Report at 77 (noting that minors "are emotionally and financially dependent on adults."). Conversion therapy "is condemned by numerous professional organizations as contraindicated, harmful, and ineffective, because minors' 'immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.'" *Otto,* 2019 WL 588645, at *21 & n.13 (quoting *Hodgson v. Minnesota,* 497 U.S. 417, 444 (1990)).

Finally, restricting the statute only to so-called "aversive" treatments such as electroshock therapy would completely disregard the overwhelming medical consensus that being subjected to non-aversive conversion therapy also puts minors at risk of depression, suicide, and other serious

harms. *See* APA Report at 42, 79-80; *Otto,* 2019 WL 588645, at *23. The government has a "compelling interest" in protecting minors from that harm, just as it does with aversive methods.

CONCLUSION

For the reasons stated above, as well as those set forth in Defendants' memoranda, *Amicus Curiae* FreeState Justice respectfully asks that the Court deny the Plaintiff's request for a preliminary injunction and grant Defendants' motion to dismiss.

March 15, 2019

Respectfully submitted,

/s/

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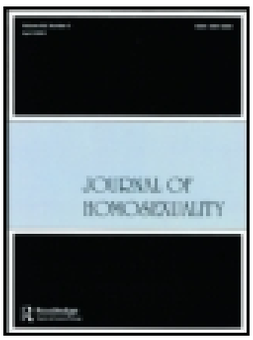

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Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment

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ABSTRACT

Studies of adults who experienced sexual orientation change efforts (SOCE) have documented a range of health risks. To date, there is little research on SOCE among adolescents and no known studies of parents' role related to SOCE with adolescents. In a cross-sectional study of 245 LGBT White and Latino young adults (ages 21–25), we measured parent-initiated SOCE during adolescence and its relationship to mental health and adjustment in young adulthood. Measures include being sent to therapists and religious leaders for conversion interventions as well as parental/caregiver efforts to change their child's sexual orientation during adolescence. Attempts by parents/caregivers and being sent to therapists and religious leaders for conversion interventions were associated with depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income. Associations between SOCE, health, and adjustment were much stronger and more frequent for those reporting both attempts by parents and being sent to therapists and religious leaders, underscoring the need for parental education and guidance.

KEYWORDS

Sexual orientation; LGBT youth; reparative therapy; conversion therapy; sexual orientation change efforts; suicidality; depression

The American Psychiatric Association removed homosexuality from its diagnostic manual as a mental disorder more than four decades ago, yet efforts to change sexual orientation, often referred to as "conversion" or "reparative" therapy, continue to be practiced by some mental health providers, clergy, and religious leaders (APA Task Force on Appropriate Therapeutic Reponses to Sexual Orientation, 2009; Substance Abuse, Mental Health Services Administration, 2015). Although research on adult populations has documented harmful effects of sexual orientation change efforts (SOCE), no studies have examined SOCE among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Yet

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because some people believe that homosexuality can be changed or "cured," some parents engage in efforts to change their child's sexual orientation, and some may seek professional therapies for a child's same-sex sexual orientation. In this study we consider the health and adjustment of a sample of lesbian, gay, bisexual, and transgender (LGBT)[1] young adults in association with retrospective reports of efforts by their parents to change their sexual orientation during adolescence.

Existing research and field consensus

SOCE continues to be practiced despite a lack of credible evidence of effectiveness, reported harm from a range of studies on SOCE with adults (see APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; SAMHSA, 2015), and increased adoption of practice guidance from major professional associations that caution against SOCE.[2] In one controversial study, 200 individuals who reported some change from homosexual to heterosexual following therapy were examined (Spitzer, 2003). The majority reported some minimal change from a homosexual to a heterosexual orientation; complete sexual orientation change was rare. The study received a great deal of attention and criticism for methodological limitations that included sample recruitment bias and problems in measurement and statistical reporting (see Drescher & Zucker, 2006 for a comprehensive review of the critiques of this study; the author later retracted the study). A review of 28 empirically based studies that have examined the use of these therapies strongly criticized the body of literature for multiple significant methodological flaws (see Serovich et al., 2008).

By the 1990s a wide range of major professional associations in the United States adopted position statements that supported affirmative care for lesbian, gay, and bisexual (LGB) clients and patients, and in the same time period several of them published statements that opposed efforts to change an individual's sexual orientation (e.g., American Academy of Pediatrics, 1993; American Psychiatric Association, 1994; American Psychological Association, 1998; National Association of Social Workers, 1992). Despite these professional statements, some providers have continued to engage in SOCE with adults and adolescents, and the American Psychological Association (APA) convened a task force in 2007 to conduct a systematic review of peer-reviewed studies related to SOCE. The task force report concluded that published studies making claims that sexual orientation had been changed were methodologically unsound (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Moreover, the report noted that SOCE were unlikely to be successful and involved risk of harm. Specifically, studies of SOCE with adults (e.g., Shidlo & Schroeder, 2002) have reported a range of negative outcomes, including depression, anxiety, self-hatred, low self-esteem, isolation, and

suicidality (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Adolescents, parents, and SOCE

At the time of the APA report, no studies were identified that focused on sexual orientation change efforts among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009); nevertheless, several organizations continued to market the effectiveness of sexual orientation change efforts for youth (see Ryan & Rivers, 2003). As the Group for the Advancement of Psychiatry—a policy organization that provides guidance for the psychiatric profession—has noted, "Despite … changes in scientific thinking in the last two decades, social and religious conservatives have advanced their own illness/behavior model of homosexuality [which] maintains that homosexuality is not inborn and that variations of long disproven theories of homosexuality's etiology can serve as a basis for offering conversion therapies" (Drescher et al., 2016, p. 8).

Understanding adolescent experiences is especially important, particularly since SOCE with minors raises distinct ethical concerns (Hicks, 1999; Substance Abuse and Mental Health Services Administration, 2015). These include determining what constitutes appropriate consent, the potential for pressure from parents and other authority figures, the minor's dependence on adults for emotional and financial support, and the lack of information regarding the impact of SOCE on their future health and wellbeing.

Concerned parents who believe that being lesbian, gay, or bisexual (LGB) is wrong and that an individual's sexual orientation can be changed may engage in rejecting behaviors, such as trying to change their child's sexual orientation; excluding them from family events and activities to discourage, deny, or minimize their identity; or using religion to prevent or change their sexual orientation (e.g., Ryan, Huebner, Diaz, & Sanchez, 2009). These parental behaviors are typically motivated by concern and represent efforts to try to help their child "fit in," to be accepted by others, to conform with religious values and beliefs, and to meet parental expectations (Morrow & Beckstead, 2004; Ryan et al., 2009; Ryan & Rees, 2012; SAMHSA, 2014). Moreover, such efforts are based on a belief that homosexuality is a mental illness or developmental disorder that needs to be corrected or cured. Yet SOCE are at odds with mainstream understandings of human development and professional standards of care, which hold that LGB identities are normative and that social stigma and minority stress contribute to negative health outcomes and self-hate (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Substance Abuse and Mental Health Services Administration, 2015).

There is growing concern that SOCE has continued to be practiced despite serious ethical conflicts and potentially harmful effects (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). An analysis by the Williams Institute estimated that nearly 700,000 U.S. LGBT adults have received SOCE conversion therapy interventions, including 350,000 LGBT adults who received SOCE interventions as adolescents (Mallory, Brown & Conron, 2018). This concern led legal advocates in the United States to introduce legislation to prevent SOCE among licensed practitioners, an approach that has been adopted in 10 U.S. states and a growing number of jurisdictions and that has sought to inform families, the public, practitioners and religious leaders of the impact of such practices (Drescher, 2013; Movement Advancement Project, 2018). Although these laws appear to have raised awareness and informed public perceptions and responses (Ames, 2015), they do not prevent SOCE in families or by unlicensed practitioners, clergy, and others.

The U.S. Substance Abuse and Mental Health Services Administration asked the APA to convene a scientific advisory panel of researchers and practitioners who were experts in the field to review existing research, professional policies, and clinical guidelines to develop consensus recommendations related to the ethical and scientific foundations of conversion therapy with minors (Substance Abuse and Mental Health Services Administration, 2015). Concurrently, the Obama administration called for an end to conversion therapy of minors, citing, in particular, the importance of family support for LGBT young people (Jarrett, 2015). Most recently, in March 2018 the European parliament passed a resolution condemning the practice and urging member nations to ban SOCE.

The current study

Historically, SOCE research has focused on adults. Decades ago, Gonsiorek theorized that the experience of SOCE during adolescence can "contribute to negative self-esteem and mental health problems" (Gonsiorek, 1988, p. 116), yet there are no known studies of the link between such interventions and the health and wellbeing of lesbian, gay, bisexual, and transgender (LGBT) young people, particularly SOCE efforts carried out both by parents and caregivers, as well as by practitioners and religious leaders.

To our knowledge, we present the first study to examine young adults' retrospective reports of parent-initiated efforts to change their sexual orientation during adolescence, and the associations between these experiences and young adult mental health and adjustment. The two goals of this study include: (1) to identify demographic and family characteristics that are associated with parent-initiated attempts to change a child's sexual

orientation during adolescence, and (2) to examine associations among these parent-initiated attempts in adolescence with a range of indicators of young adult health and adjustment.

Method

The sample included 245 participants who self-identified as LGBT. Participants were recruited from local bars, clubs, and community agencies that serve this population in a 100-mile radius of the research center. Screening procedures were used to select participants into the study based on the following criteria: age (21–25); ethnicity (White, Latino, or Latino mixed); self-identification as LGBT during adolescence; being open about LGBT status to at least one parent or guardian during adolescence; and having lived with at least one parent or guardian during adolescence at least part-time. The survey was administered in both English and Spanish, and it was available in either computer-assisted or paper-and-pencil format. The study protocol was approved by the university's institutional review board.

Sample

Of the 245 participants, 46.5% were male, 44.9% were female, and 8.6% were transgender. The majority of participants identified as gay (42.5%), 27.8% as lesbian, 13.1% as bisexual, and 16.7% as other (e.g., queer, dyke, homosexual). Approximately one half of the sample identified as Latino (51.4%), and the other 48.6% identified as White, non-Latino. In addition, 18.78% of the respondents were immigrants to the United States. The age of the participants ranged from 21 to 25 years (M = 22.8, SD = 1.4). Family of origin socioeconomic status was assessed retrospectively (1 = *both parents in unskilled positions or unemployed* to 16 = *both parents in professional positions;* M = 6.75, SD = 4.77).

Measures

Parent-initiated efforts to change youths' sexual orientation

Participants responded to two items that assessed past parental and caregiver-initiated efforts to change the youths' sexual orientation. The first item asked: "Between ages 13 and 19, how often did any of your parents/caregivers try to change your sexual orientation (i.e., to make you straight)?" (0 = never [49.64%]; 1 = ever [53.06%]). A second item asked: "Between ages 13 and 19, how often did any of your parents/caregivers take you to a therapist or religious leader to cure, treat, or change your sexual orientation?" (0 = never [65.71%]; 1 = ever [34.29%]). We created a single measure with

three categories that identifies the severity of parent-initiated attempts to change youths' sexual orientation. The three categories include: (1) no attempt to change sexual orientation (n = 109; 41.63%), (2) parent and caregiver-initiated attempt to change sexual orientation without external conversion efforts (n = 52; 21.22%), and (3) parent and caregiver-initiated attempt to change sexual orientation with external conversion efforts (n = 78; 31.84%). Six participants who reported conversion efforts but not parental attempts to change sexual orientation were dropped from the current study, for a total analytic sample of 239 participants.

Young adult health and adjustment

Indicators of mental health and adjustment assessed included suicidal ideation, lifetime suicidal attempts, depression, self-esteem, and life satisfaction. Suicidal ideation was assessed by one item: "During the past six months, did you have any thoughts of ending your life?" (0 = no, 3 = many times). Lifetime suicidal attempts were assessed by one item: "Have you ever, at any point in your life, attempted taking your own life?" (0 = no, 1 = yes). Depression was measured by the 20-item CES-D (Radloff, 1977, 1991). Two dichotomized cut-off scores were also used: a clinical cut-off score (≥16) and a prescription intervention cut-off score (≥22). Self-esteem was measured by Rosenberg's 6-item self-esteem scale (Rosenberg, 1979). Life satisfaction was measured by an 8-item scale (e.g., "At the present time, how satisfied are you with your living situation?"). Social support was measured by the 12-item Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988).

Behavioral health risk indicators included substance use and abuse and engagement in risky sexual activities. Binge drinking (or heavy alcohol use) was assessed by two items that measured the frequency of drinking and the number of drinks per occasion (0 = less than 1–2 times per week and less than 3 drinks per occasion; 1 = 1–2 times per week or more and more than 3 drinks per occasion). Substance abuse problems were assessed by four items (e.g., "In the past five years, have you had problems with the law because of your alcohol or drug use?") and were dichotomized to represent ever having problems versus never having problems. Risky sexual behavior was assessed in six ways: unprotected sex during the last 6 months (0 = no, 1 = yes), unprotected sex with a casual or HIV positive partner during the last 6 months (0 = no, 1 = yes), unprotected sex during last sexual encounter (0 = no, 1 = yes), unprotected casual sex during last sexual encounter (0 = no, 1 = yes), ever been diagnosed with a sexually transmitted disease (0 = never, 1 = ever), and one item that assessed HIV risk ("In the last six months, were you ever at risk for being infected with or transmitting HIV?"; 0 = no, 1 = yes).

Finally, two indicators of young adult socioeconomic status were assessed: current monthly income and educational attainment. Current weekly income as assessed by one item: "What is your personal weekly income (after taxes,

unemployment, social security, etc.)?" (1 = less than $100, 7 = more than $2000). Educational attainment was assessed by one item: "What is the highest level of education you have completed?" (1 = *less than elementary school*, 7 = *postgraduate*).

Demographic and family characteristics

Adolescent gender nonconformity and family religiosity were included as possible characteristics that may predict whether or not parents/caregivers attempted to change the participant's sexual orientation during adolescence. Adolescent gender nonconformity was measured by one item: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself when you were a teenager (age 13–19)?" This item was reverse coded for males such that a higher score is representative of more nonconformity to gender norms ($M = 4.40$, $SD = 1.87$). Family religiosity was measured by one item: "How religious or spiritual was your family while you were growing up?" (0 = *not at all*, 3 = *extremely; M* = 1.35, *SD* = 0.91).

Plan of analysis

First, demographic and family characteristics were included in a multinomial logistic regression to predict the likelihood of a participant experiencing parent-initiated attempts to change their sexual orientation during adolescence without external conversion intervention efforts (= 1) and parental attempts to change sexual orientation with external conversion efforts (= 2) compared to no attempts (= 0). Second, to understand the associations among parent-initiated attempts to change the participant's sexual orientation during adolescence with young adult health and wellbeing, we used logistic regressions for dichotomous outcomes and multiple linear regression for continuous outcomes, including known covariates for the outcomes of interest (Ryan et al., 2009). To minimize exclusion of participants due to missing data and to maximize statistical power, we used PRELIS, a component of LISREL, to impute missing data (total <5%; Graham, Cumsille, & Elek-Fisk, 2003) using all numeric variables in an expectation maximization algorithm for imputation. All continuous variables were checked for assumptions of normality; the depression measure was significantly skewed, but after a square-root transformation the items met assumptions of normality. Finally, we conducted linear trend analyses for study outcomes across the three groups of participants based on no attempts, parent-initiated attempts, and parent-initiated attempts with external conversion efforts.

Results

Similar background characteristics predicted both types of parent-initiated SOCE (see Table 1). Notably, there were no differences in reports of SOCE

Table 1. Demographic and family characteristics predicting parent/caregiver-initiated sexual orientation change efforts.

	Parent-initiated SOCE	Parent-initiated SOCE with external conversion efforts
Female (Ref = male)	1.62 (0.76–3.46)	0.94 (0.46–1.92)
Transgender (Ref = male)	2.30 (0.40–13.14)	1.93 (0.44–8.47)
Bisexual (Ref = gay/lesbian)	0.80 (0.30–2.17)	0.40 (0.13–1.23)
Queer (Ref = gay/lesbian)	0.49 (0.14–1.74)	1.24 (0.46–3.34)
White, non-Latino (Ref = Latino)	0.86 (0.39–1.90)	1.51 (0.70–3.23)
Immigrant (Ref = U.S. native)	1.98 (0.67–5.90)	6.47 (2.43–17.23)***
Family of origin SES	0.85 (0.78–0.93)***	0.88 (0.81–0.95)***
Adolescent gender nonconformity	1.18 (0.96–1.45)	1.27 (1.05–1.54)*
Family religiosity	1.72 (1.13–2.61)*	1.88 (1.28–2.76)**

N = 239. Ref = reference group. Adjusted odds ratios and 95% confidence intervals from a multinomial logistic regression are shown. The reference category for the model was "neither change efforts nor conversion efforts." ***$p < .001$. **$p < .01$. *$p < .05$.

based on gender, sexual identity (bisexual or queer), or ethnicity. However, adolescents who grew up in religious families were more likely to experience SOCE (with and without external conversion efforts). Higher family of origin socioeconomic status was also associated with fewer parent-initiated SOCE (with and without conversion efforts). Additionally, participants who were not born in the United States and who reported more gender nonconformity during adolescence were more likely to experience parent-initiated attempts to change with external conversion efforts.

Table 2 displays the results of logistic and linear regressions predicting young adult health and adjustment based on reports of parent-initiated SOCE during adolescence (both with and without external conversion efforts). Both levels of parent-initiated attempts to change participant's sexual orientation during adolescence were associated with more negative mental health problems for young adults. Specifically, those who experienced SOCE were more likely to have suicidal thoughts (although only for those who reported SOCE with external conversion efforts) and to report suicidal attempts and higher levels of depression. Participants who experienced SOCE had lower life satisfaction and less social support in young adulthood. Parental-initiated SOCE in adolescence were not associated with self-esteem, substance use or abuse, or risky sexual behavior. Finally, parent-initiated SOCE during adolescence were associated with lower young adult socioeconomic status: less educational attainment and less weekly income (although only for those who experienced attempts to change with external conversion efforts).

Differences across the three groups defined by parent-initiated SOCE are presented in Table 3. Trend analyses confirmed that parental attempts to change adolescents' sexual orientation are significantly associated with negative health outcomes in young adulthood, and that those problems are worse

Table 2. Parent/caregiver-initiated sexual orientation change efforts predicting young adult outcomes.

	Parent-initiated SOCE	Parent-initiated SOCE with external conversion efforts
Mental Health		
Suicidal ideation (continuous)	0.13	0.27***
Suicidal attempt (1 = ever)	3.08 (1.39–6.83)**	5.07 (2.38–10.79)***
Depression – Clinical cut-off score (≥16)	2.20 (1.02–4.73)*	3.92 (1.92–8.00)***
Depression – Prescription intervention cut-off score (≥22)	1.94 (0.82–4.57)	3.63 (1.67–7.87)**
Depression (continuous)	0.15*	0.30***
Self-esteem (continuous)	−0.13	−0.13
Life satisfaction (continuous)	−0.19**	−0.34***
Social support (continuous)	−0.26***	−0.45***
Substance Use/Abuse		
Binge drinking (1 = yes)	0.90 (0.42–1.93)	1.01 (0.50–2.03)
Substance abuse problems (1 = yes)	0.87 (0.42–1.82)	1.70 (0.84–3.44)
Sexual Risk Behavior		
Unprotected sex during last 6 months (1 = yes)	1.61 (0.70–3.72)	2.05 (0.91–4.59)
Unprotected sex with casual or HIV + partner last 6 months (1 = yes)	0.91 (0.36–2.30)	2.09 (0.91–4.78)
Unprotected sex at last intercourse (1 = yes)	0.90 (0.43–1.87)	1.23 (0.62–2.45)
Unprotected casual sex at last intercourse (1 = yes)	1.01 (0.41–2.49)	1.11 (0.48–2.58)
STD diagnosis (1 = ever)	0.79 (0.33–1.91)	1.36 (0.62–2.99)
HIV risk in last 6 months (1 = yes)	0.74 (0.31–1.74)	1.06 (0.50–2.26)
Current Socioeconomic Status		
Educational attainment (continuous)	−0.15*	−0.32***
Current weekly income (continuous)	−0.12	−0.27***

N = 239. Adjusted odds ratios and 95% confidence intervals are shown for dichotomous outcomes and standardized beta coefficients are shown for continuous outcomes. All analyses controlled for gender, sexual orientation, ethnicity, immigrant status, family of origin socioeconomic status, adolescent gender nonconformity, and family of origin religiosity. ***$p < .001$. **$p < .01$. *$p < .05$.

for young adults who experienced SOCE that included external conversion efforts during adolescence. This pattern of results emerged as statistically significant for 12 of the 18 outcomes tested, including significant findings for all outcomes related to mental health and socioeconomic status.

Discussion

Results from this study clearly document that parent/caregiver efforts to change an adolescent's sexual orientation are associated with multiple indicators of poor health and adjustment in young adulthood. The negative associations were markedly stronger for participants who experienced both parental attempts to change their sexual orientation, coupled with efforts to send the adolescent to a therapist or religious leader to change their sexual orientation (strategies often called "conversion" or "reparative" therapy). In this sample of LGBT young adults, more than half reported some form of

Table 3. Trend effects related to parent/caregiver-initiated sexual orientation change efforts predicting young adult health outcomes.

	No SOCE (n = 109)	Parent-Initiated SOCE (n = 52)	Parent-Initiated SOCE with External Conversion Efforts (n = 78)	Group difference (χ^2; F)
Mental Health				
Suicidal ideation (continuous)	.17	.38	.57	***
Suicidal attempt (1 = ever)	22.0 %	48.1 %	62.8 %	***
Depression – Clinical cut-off score (≥16)	26.6 %	46.2 %	65.4 %	***
Depression – Prescription intervention cut-off score (≥22)	15.6 %	32.7 %	52.3 %	***
Depression (continuous)	9.21	12.99	16.10	***
Self-esteem (continuous)	2.88	2.74	2.72	**
Life satisfaction (continuous)	3.05	2.78	2.61	***
Social support (continuous)	4.18	3.66	3.31	***
Substance Use/Abuse				
Binge drinking (1 = yes)	42.2 %	36.5 %	41.3 %	NS
Substance abuse problems (1 = yes)	49.5 %	50.0 %	66.7 %	*
Sexual Risk Behavior				
Unprotected sex during last 6 months (1 = yes)	28.4 %	36.5 %	42.3 %	*
Unprotected sex with casual or HIV + partner last 6 months (1 = yes)	22.0 %	21.2 %	38.5 %	*
Unprotected sex at last intercourse (1 = yes)	49.5 %	53.9 %	59.0 %	NS
Unprotected casual sex at last intercourse (1 = yes)	15.6 %	23.1 %	25.6 %	NS
STD diagnosis (1 = ever)	24.8 %	21.2 %	30.8 %	NS
HIV risk in last 6 months (1 = yes)	28.4 %	25.0 %	37.2 %	NS
Current Socioeconomic Status				
Educational attainment (continuous)	5.19	4.65	4.26	***
Current weekly income (continuous)	2.73	2.31	2.03	***

Six participants who reported conversion efforts but not parent attempts are excluded. Percentages are shown for dichotomous outcomes with chi-square significance levels, and average scores are shown for continues outcomes with ANOVA F significance levels.
***$p < .001$. **$p < .01$. *$p < .05$.

attempt by their parents and caregivers to change their sexual orientation during adolescence. With the exception of high-risk sexual behavior and substance abuse, attempts to change sexual orientation during adolescence were associated with elevated young adult depressive symptoms and suicidal behavior, and with lower levels of young adult life satisfaction, social support, and socioeconomic status. Thus SOCE is associated with multiple domains of functioning that affect self-care, wellbeing, and adjustment.

The results of this study point to a number of factors that impact practice and provision of appropriate care. Family religiosity was strongly linked to

parental attempts to change sexual orientation. In a related study, families that were highly religious were least likely to accept their LGBT children (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Religiously conservative families often have misinformation about sexual orientation and gender identity and need accurate information to help support their LGBT children in the context of their values and beliefs (for guidance see Ryan & Rees, 2012; Substance Abuse Mental Health & Services Administration, 2014). Moreover, parents and caregivers often conflate sexual orientation with gender expression. Discomfort with gender nonconformity may be at the root of much of parents' and caregivers' motivations for SOCE: in the current study, gender nonconforming youth were more likely to experience attempts to change their sexual orientation through conversion therapy with therapists and religious leaders. Further, our results show that immigrant parents are more likely to try to change their children's sexual orientation by sending them for clinical or religious intervention.

Related research has found that SOCE typically happens in the context of other family rejecting behaviors that contribute to health risks in young adulthood (Ryan et al., 2009). Parents, caregivers and others who provide support for LGBT children and adolescents need to understand that family rejection encompasses a wide range of behaviors, and education is critical for families, providers, and religious leaders on the relationship between family rejection and acceptance with health and wellbeing for LGBT young people (Ryan, 2009; Ryan & Chen-Hayes, 2013; Ryan et al., 2010; Substance Abuse and Mental Health Services Administration, 2015; Substance Abuse Mental Health & Services Administration, 2014).

Studies on responses of parents and caregivers with LGBT children indicate that parents' reactions are motivated by a number of concerns, which include helping their child "fit in" to their family and cultural world, responding to religious and cultural values, keeping their families together, and trying to protect their LGBT child from harm (Maslowe & Yarhouse, 2015; Ryan, 2009; Substance Abuse Mental Health & Services Administration, 2014). In other words, parents are typically motivated by doing what they think is best for their child. Nonetheless, our study did not directly examine the motives of the parents of study participants. However, these findings reinforce the critical need for culturally appropriate family education and guidance on sexual orientation and gender identity and expression, the harmful effects of family rejecting behaviors, including SOCE, and the need for supporting their LGBT children, even in the context of parental and familial discomfort and religious conflict.

There are several limitations of this study. First, study inclusion criteria called for current identification as LGBT; it is likely that this inclusion criterion excludes persons who are dissatisfied with their LGBT identity, or persons who had identified as LGBT during adolescence but not at the time

of the study. Thus we acknowledge that we did not include young people whose sexual orientation may be more fluid (e.g., sexual orientation in adolescence not consistent with sexual orientation in young adulthood). Second, although the study included a measure of family religiosity, there is no measure of specific religious affiliation, a factor that might be a further predictor of the role of parents in SOCE of their children. Third, the design is retrospective, and thus causal claims cannot be made. We cannot rule out the possibility that those who were most maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related SOCE. However, we note that the face validity of the specific measures is compelling: the alternatives are less plausible than the explanation that sexual orientation change attempts would likely undermine health and wellbeing.

Most attention to SOCE has focused on the ethics of professional practice and recent efforts to end such practice through legislation. This study highlights the crucial role parents play in SOCE—either directly themselves or through sending their children to therapists or religious leaders. Results point to the need for multicultural and faith-based family education resources and approaches to help parents and caregivers learn how to support their LGBT children in the context of their family, cultural, and religious values (see, for example, Kleiman & Ryan, 2013; Ryan, 2009; Ryan & Rees, 2012). In addition to supporting families and educating religious leaders and congregations, legislative and professional regulatory efforts to end SOCE therapies are important for raising awareness about and preventing a contraindicated practice that contributes to health risks, and for changing negative attitudes and bias regarding LGBT people.

Taken together, these findings provide a needed empirical framework for understanding the scope of SOCE in and outside of the home and the costs of sexual orientation change efforts directly from those individuals who are most affected—LGBT young people themselves. Historically, research and strategies to prevent SOCE have focused on mental health practitioners and much less on religious leaders, with limited awareness of the role of families in pressuring LGBT young people to change core identities. As indicated by this study, more attention is needed on family-based efforts to change a child's sexual orientation and gender expression. Because LGBT youth cannot escape family rejecting behaviors (see, for example, Ryan, 2009; Ryan & Rees, 2012), approaches to prevent and ameliorate efforts to change a child's sexual orientation and gender identity must include the broader social context that includes the home and social, cultural, and religious influences on families and caregivers to change or suppress a child's sexual orientation and gender expression.

Notes

1. The sampling frame for the study included youth who identified as LGBT during adolescence. Of note, all transgender youth in this sample also identified as lesbian/gay, bisexual, homosexual, or queer.
2. Policy statements cautioning against SOCE have been issued across disciplines ranging from counseling (American Counseling Association, 2013) to medicine (Society for Adolescent Health and Medicine, 2013), nursing (International Society of Psychiatric-Mental Health Nurses, 2008), psychiatry (American Psychiatric Association, 2000; World Psychiatric Association, 2016), psychology (American Psychological Association, 2009), and social work (National Association of Social Workers, 2015).

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