No. 19-10604

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, and JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,
Plaintiffs–Appellants

v.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA
Defendants–Appellees

On Appeal from the United States District Court
for the Southern District of Florida
In Case No. 9:18-cv-80771-RLR before the Honorable Robin L. Rosenberg

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Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

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Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

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Originating Office
Division of Systems Development, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services.

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Executive Summary

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

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

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

Key Findings

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

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

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Understanding Sexual Orientation and Gender Identity in Children and Youth

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

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

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

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

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

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

Therapeutic Efforts with Sexual and Gender Minority Youth[4]

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

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

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

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

Ending the Use of Conversion Therapy for Minors

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

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Introduction

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

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

In addition, this report highlights areas of opportunity for future research, and provides an overview of mechanisms to eliminate the use of harmful therapies. In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: *Family and Community Acceptance*,

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

School-Based Issues, *Pediatric Considerations*, and *Affirmative Exploratory Therap* . In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

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

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

Professional Consensus Process

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

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

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

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

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

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

Sue Thau

Statements of Professional Consensus

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

Guiding Principles

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

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

Professional Consensus on Conversion Therapy with Minors

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

Professional Consensus on Sexual Orientation in Youth

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

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

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

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.

4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.

5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

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

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.

7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

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

Peri-Pubertal Adolescents

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

Pubertal and Post-Pubertal Adolescents

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

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

Research Overview

Sexual Orientation

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

Gender

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

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

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

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

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

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

Gender Identity and Gender Expression in Childhood

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

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

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

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

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

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

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

Clinical Issues in Childhood

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

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

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

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

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

Gender Identity in Adolescence

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

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

Clinical Issues in Adolescence

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

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

Influences on Health and Well-Being

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

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

Family

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

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

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

Religion & Spirituality

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

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

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

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

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity.

Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

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

School

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

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

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

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

Identity Development

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

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

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

Intersecting Identities

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

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction[16]

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

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

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

Conversion Therapy

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

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

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

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

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

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

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

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

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

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

Client-Centered Individual Approaches

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

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

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

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

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

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

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

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Family Approaches

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

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

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

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

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

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

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

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

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

School and Community Interventions

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

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

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

Additional Appropriate Approaches with Gender Minority Youth

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

Social Transition

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

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

Medical Intervention

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

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

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

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

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

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

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

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

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

Future Directions for Research

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

Development of sexual orientation and gender identity

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

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

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

Addressing the needs of disconnected LGBTQ youth

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

Long-term Outcomes

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

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

Integration, Collaboration, and Dissemination

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

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

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

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

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

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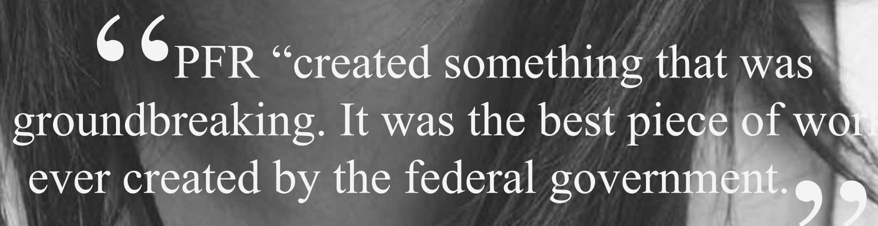

"PFR "created something that was groundbreaking. It was the best piece of work ever created by the federal government."

Sue Thau

Approaches to Ending the Use of Conversion Therapy

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

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

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

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

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

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

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

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

Dissemination of information, training and education for behavioral health providers

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

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

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

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

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

Legislative, regulatory, and legal efforts

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

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

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

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

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

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

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

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

Guidance for Families, Providers, and Educators

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

Promoting Family and Community Acceptance and Support

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

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

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

Key Points:

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

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

Resources

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

Gender Spectrum: www.genderspectrum.org

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

PFLAG : www.pflag.org

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Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x

Seil, K. S., Desai, M. M., & Smith, M. V. (2014). Sexual orientation, adult connectedness, substance use, and mental health outcomes among adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health, 104*(10), 1950-1956.

Substance Abuse and Mental Health Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. (HHS Publication No. PEP14-LGBTKIDS). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from http://store.samhsa.gov/product/PEP14-LGBTKIDS.

Bullying, Harassment, and Other School-Based Issues

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

Key points:

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

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

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

Resources:

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

GLSEN: www.glsen.org

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

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

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

PFLAG : www.pflag.org

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

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National Association of School Psychologists. (2014). NASP Position statement: Safe schools for transgender and gender diverse students, from http://www.nasponline.org/about_nasp/positionpapers/Transgender_PositionStatement.pdf

Orr, A., Baum, J., Gill, E., Kahn, E., & Salem, A. (2015, August). Schools in transition: A guide for supporting transgender students in K-12 schools, from http://www.nclrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf

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U.S. Department of Education. (2014). Questions and answers on Title IX and sexual violence, from http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf

U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S. Department of Justice, Civil Rights Division, from http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf

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

—Amy

Pediatric Care Considerations for LGBTQ Children and Adolescents

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

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

Key points:

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

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

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

Resources:

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

Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

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

—Malachi

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): International Journal of Transgenderism.

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Affirmative Care for Gender Minority Youth

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

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

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

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

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

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

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

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

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

—Mathew

Summary and Conclusion

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

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

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

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

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

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Appendix A: Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Acknowledgments

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

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

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

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

Endnotes

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

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

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Annals of Internal Medicine POSITION PAPER

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

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

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

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

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

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

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

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

METHODS

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

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

ACP Position Statements and Recommendations

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

From the American College of Physicians, Washington, DC.

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

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

Understanding the LGBT Community

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

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

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

Access to Care in the LGBT Population

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

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

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

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

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

Mental and Physical Health Disparities

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

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

Positions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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RBC015782

96-1

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

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

DECLARATION OF PLAINTIFF JULIE H. HAMILTON, PH.D., LMFT

1. I am over the age of 18 years, and I am a named Plaintiff in this case. I have personal knowledge of the matters set forth in this declaration, and would testify competently as to such matters if called to do so.

2. Since the filing of the Verified Complaint in this action on June 13, 2018 (DE 1), I have taken the following actions in connection with my professional practice as a licensed marriage and family therapist in Palm Beach County, Florida:

   a. Paid the City of Boca Raton local business tax for the annual periods ending September 30, 2018 and September 30, 2019 (true and correct copies of my City of Boca Raton Business Tax Receipt/Certificate of Use for the annual period ending September 30, 2018, and my Payment Receipt for my online payment of the City of Boca Raton local business tax for the annual period ending September 30, 2019, are attached hereto as Exhibits A-1 and A-2, respectively);

   b. Paid the Palm Beach County local business tax for a Boca Raton office for the annual period ending September 30, 2019 (a true and correct copy of my Palm Beach County Local Business Tax Receipt for the annual period ending September 30, 2019 is attached hereto as Exhibit A-3).

   c. Provided in-person counselling in the City of Boca Raton consistent with my licensure and applicable law.

I DECLARE under penalty of perjury that the foregoing is true and correct.

EXECUTED this October 9, 2018.

/s/ Julie H. Hamilton
Julie H. Hamilton

LOCAL BUSINESS TAX
RECEIPT # 18 00069044

CITY OF BOCA RATON
BUSINESS TAX AUTHORITY

THIS IS NOT A BILL
Any changes in name, address, suite, ownership, ect. will require a new application within 15 days to avoid penalty or the license is null and void.

HAMILTON, JULIE HARREN
HAMILTON, JULIE HARREN
4400 N FEDERAL HWY 21

BUSINESS TAX RECEIPT
CERTIFICATE OF USE
EXPIRES: 9/30/18

Business Tax fee:	26.25
Penalty fee:	.00
Late fee:	.00
Additional fee:	73.00
Transfer fee:	.00
Total paid:	**99.25**

HAMILTON, JULIE HARREN
2853 WHITE TROUT LN
WEST PALM BEACH FL 33411

has paid the business tax at the above address for the period beginning the 1st day of October and ending the 30th day of September to engage in the business, profession or occupation of:

Classification: EXECUTIVE SUITE SERVICE OTC
Comments: MARRIAGE AND FAMILY THERAPY

WELCOME to the City of Boca Raton. We are proud to have your business in our community. You may call us at 561-393-7937 if you have questions relating to your business needs. We are located at 200 NW 2 Avenue. Lobby hours are 8:00 AM to 4:00 PM Monday thru Friday, except Wednesday, hours are 8:00 AM to 3:00 PM. Our mailing address is 201 W. Palmetto Park Rd, Boca Raton, FL. 33432.

VERIFY all information on your Business Tax Receipt / Certificate of Use and notify us immediately if there is an error.

CHANGES REQUIRE A NEW APPLICATION TO BE SUBMITTED WITH APPROPRIATE FEE(S) AND DOCUMENTATION WITHIN 15 DAYS OF THE CHANGE. If you make any changes to the business; examples: change of location within the City, expansion of space, change of ownership, change of business name, change of applicant/qualifier name, change of mailing address, change in nature of business operated, or add a new type of business at the same or at a different location, a new application must be filed within 15 days of the change in order to keep the account current and avoid paying a penalty. Make sure Division of Corporations reflects all changes.

VISIT our website at: WWW.MYBOCA.US, click on 'BUSINESS', then 'BUSINESS TAX', then on the left side, click on 'FORMS AND REPORTS' to download both City and County applications.

POST the top portion of this document at the above location in a place where it may be seen at all times.

DEACTIVATION: If you cease to operate this business entity, you must return this document to our office with proof that the Division of Corporations filing has been inactivated, including both Corporate and Fictitious Name filings. If the business location has changed, provide proof that the principal address has been changed on Division of Corporations. All signage for discontinued business must be removed within 10 days.

A COURTESY RENEWAL NOTICE will be sent 30 to 60 days prior to expiration. If you do not receive the renewal notice, you must still pay the tax on time. Late penalties will not be waived if you do not receive the notice. The Business Tax may be renewed in person, by drop-box in City Hall, by mail or by using the website and Click "e-services". To renew online you will need your Business Tax Receipt # and "pin" #. These numbers will be provided on your renewal notice on the top right corner.

NOTE: At this time classifications that need a license/permit/certification or regulated requirement cannot renew online.

FAILURE TO PAY your Business Tax on or before the close of business on September 30 will cause penalties to be applied to the business tax renewal as indicated below.

PAYMENT AND PENALTY SCHEDULE

DATE PENALTY EFFECTIVE:	SEPT 30	OCT 1	NOV 1	DEC 1	JAN 1	MAR 1
PENALTY:	0%	10%	15%	20%	25%	25% + $250.00

EXHIBIT A-1

Payment Receipt

Thank you for your payment.

Transaction Results:

Transaction Status

Success

Auth Code

09516D

Reference Number

93140084

Payment Method:

Charged To

Visa ************3224

Account Holder

Hamilton, Julie H

Billing Address

2853 White Trout Ln, West Palm Beach, FL 33411

Transaction Overview:

Total Amount

$105.00

Payment Date

EXHIBIT A-2

Charge Details

Charge Description	Amount
18-00069044	$105.00
Total	**$105.00**

« Go back and pay for a different account. (./index.html?OWASP_CSRFTOKEN=U5TB-SPAY-RTGU-TRDE-2P5W-Y0K7-56BB-T1MY)

ANNE M. GANNON
CONSTITUTIONAL TAX COLLECTOR
Serving Palm Beach County
Serving you.

P.O. Box 3353, West Palm Beach, FL 33402-3353
www.pbctax.com Tel: (561) 355-2264

LOCATED AT

4400 North Federal HWY Ste 210
BOCA RATON, FL 33431

PE OF BUSINESS	OWNER	CERTIFICATION #	RECEIPT #/DATE PAID	AMT PAID	BILL #
IAGE & FAMILY THERAPIST	HAMILTON JULIE HARREN	MT1728	U18.743703 - 09/28/18	$33.00	B40192049

is valid only when receipted by the Tax Collector's Office.

STATE OF FLORIDA
PALM BEACH COUNTY
2018/2019 LOCAL BUSINESS TAX RECEIPT

JULIE HARREN
JULIE HARREN
2853 WHITE TROUT LANE
WEST PALM BEACH, FL 33411

LBTR Number: 2018112160
EXPIRES: SEPTEMBER 30, 2019

This receipt grants the privilege of engaging in or managing any business profession or occupation within its jurisdiction and MUST be conspicuously displayed at the place of business and in such a manner as to be open to the view of the public.

EXHIBIT A-3

121-1

Case No. 9:18-CV-80771-RLR
Exhibit No. 1
Defendant County of Palm Beach

1

ORDINANCE NO. 2017-046

AN ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, ESTABLISHING THE "PROHIBITION OF CONVERSION THERAPY ON MINORS ORDINANCE"; PROVIDING FOR INTENT; PROVIDING FOR A TITLE; PROVIDING FOR APPLICABILITY; PROVIDING FOR DEFINITIONS; PROVIDING FOR VIOLATIONS; PROVIDING FOR PENALTIES; PROVIDING FOR ENFORCEMENT; PROVIDING FOR REPEAL OF LAWS IN CONFLICT; PROVIDING FOR SEVERABILITY; PROVIDING FOR INCLUSION IN THE CODE OF LAWS AND ORDINANCES; PROVIDING FOR CAPTIONS; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, as recognized by major professional associations of mental health practitioners and researchers in the United States and elsewhere for nearly 40 years, being lesbian, gay, bisexual, transgender or gender nonconforming, or questioning (LGBT or LGBTQ) is not a mental disease, disorder, illness, deficiency or shortcoming; and

WHEREAS, the American Academy of Pediatrics in 1993 published an article in its Journal, Pediatrics, stating: "Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation;" and

WHEREAS, the American Psychiatric Association in December 1998 published its opposition to any psychiatric treatment, including reparative or conversion therapy, which therapy regime is based on the assumption that homosexuality is a mental disorder per se or that a patient should change his or her homosexual orientation; and

~~**WHEREAS,** the American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation conducted a systematic review of peer-reviewed journal literature on Sexual Orientation Change Efforts ("SOCE") and issued its report in 2009, citing research that SOCE can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame towards parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources; and~~

Attachment 1
PBC 000001

1 **WHEREAS,** The American Psychological Association in 2009 issued a resolution on
2 Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts,
3 advising parents, guardians, young people, and their families "to avoid sexual orientation
4 change efforts that portray homosexuality as a mental illness or developmental disorder and to
5 seek psychotherapy, social support, and educational services that provide accurate information
6 on sexual orientation and sexuality, increase family and school support, and reduce rejection of
7 sexual minority youth"; and

8 **WHEREAS,** The American Psychoanalytic Association in June 2012 issued a position
9 statement on conversion therapy efforts, articulating that "As with any societal prejudice, bias
10 against individuals based on actual or perceived sexual orientation, gender identity or gender
11 expression negatively affects mental health, contributing to an enduring sense of stigma and
12 pervasive self-criticism through the internalization of such prejudice" and that psychoanalytic
13 technique "does not encompass purposeful attempt to 'convert,' 'repair,' change or shift an
14 individual's sexual orientation, gender identity or gender expression," such efforts being
15 inapposite to "fundamental principles of psychoanalytic treatment and often result in
16 substantial psychological pain by reinforcing damaging internalized attitudes"; and

17 **WHEREAS,** the American Academy of Child & Adolescent Psychiatry in 2012
18 published an article in its Journal, Journal of the American Academy of Child and Adolescent
19 Psychiatry, stating that "[c]linicians should be aware that there is no evidence that sexual
20 orientation can be altered through therapy and that attempts to do so may be harmful. There is
21 no empirical evidence adult homosexuality can be prevented if gender nonconforming children
22 are influenced to be more gender conforming. Indeed, there is no medically valid basis for
23 attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may
24 encourage family rejection and undermine self-esteem, connectedness and caring, important
25 protective factors against suicidal ideation and attempts. Given that there is no evidence that
26 efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that
27 they carry the risk of significant harm, such interventions are contraindicated"; and

28 **WHEREAS,** the Pan American Health Organization, a regional office of the World
29 Health Organization, issued a statement in 2012 stating: "These supposed conversion therapies
30 constitute a violation of the ethical principles of health care and violate human rights that are
31 protected by international and regional agreements." The organization also noted that

1 reparative therapies "lack medical justification and represent a serious threat to the health and
2 well-being of affected people;" and
3 **WHEREAS**, in 2014 the American School Counselor Association issued a position
4 statement that states: "It is not the role of the professional school counselor to attempt to
5 change a student's sexual orientation or gender identity. Professional school counselors do not
6 support efforts by licensed mental health professionals to change a student's sexual orientation
7 or gender as these practices have been proven ineffective and harmful"; and
8 **WHEREAS**, a 2015 report of the Substance Abuse and Mental Health Services
9 Administration, a division of the U.S. Department of Health and Human Services, "Ending
10 Conversion Therapy: Supporting and Affirming LGBTQ Youth" further reiterates based on
11 scientific literature that conversion therapy efforts to change an individual's sexual orientation,
12 gender identity, or gender expression, is a practice not supported by credible evidence and has
13 been disavowed by behavioral health experts and associations; perpetuates outdated views of
14 gender roles and identities, and negative stereotypes; and may put young people at risk of
15 serious harm. The report recognizes that same-gender sexual orientation (including identity,
16 behavior, and attraction) is part of the normal spectrum of human diversity and does not
17 constitute a "mental disorder; and
18 **WHEREAS**, the American College of Physicians wrote a position paper in 2015
19 opposing the use of "conversion," "reorientation," or "reparative" therapy for the treatment of
20 LGBT persons, stating that "[a]vailable research does not support the use of reparative therapy
21 as an effective method in the treatment of LGBT persons. Evidence shows that the practice
22 may actually cause emotional or physical harm to LGBT individuals, particularly adolescents
23 or young persons"; and
24 **WHEREAS**, two federal appeals courts found that a prohibition of SOCE does not
25 violate first amendment rights and noted that the subject laws only required mental health
26 providers who wish to engage in practices that seek to change a minor's sexual orientation
27 either to wait until the minor turns 18 or be subject to professional discipline, leaving mental
28 health providers free to discuss or recommend treatment and to express their views on any
29 topic; and
30 **WHEREAS**, Palm Beach County does not intend to prevent mental health providers
31 from speaking to the public about SOCE; expressing their views to patients; recommending
32 SOCE to patients; administering SOCE to any person who is 18 years of age or older; or

1 referring minors to unlicensed counselors, such as religious leaders. This Ordinance does not
2 prevent unlicensed providers, such as religious leaders, from administering SOCE to children
3 or adults; nor does it prevent minors from seeking SOCE from mental health providers in other
4 political subdivisions outside of Palm Beach County, Florida; and

5 **WHEREAS**, Palm Beach County has a compelling interest in protecting the physical
6 and psychological well-being of minors, including but not limited to lesbian, gay, bisexual,
7 transgender and questioning youth, and in protecting its minors against exposure to serious
8 harms caused by sexual orientation and gender identity change efforts; and

9 **WHEREAS**, the Palm Beach County Board of County Commissioners hereby finds the
10 overwhelming research demonstrating that sexual orientation and gender identity change efforts
11 can pose critical health risks to lesbian, gay, bisexual, transgender or questioning persons, and
12 that being lesbian, gay, bisexual, transgender or questioning is not a mental disease, mental
13 disorder, mental illness, deficiency, or shortcoming; and

14 **WHEREAS**, the Palm Beach County Board of County Commissioners finds minors
15 receiving treatment from licensed therapists in Palm Beach County who may be subject to
16 conversion or reparative therapy are not effectively protected by other means, including, but
17 not limited to, other state statutes, local ordinances, or federal legislation; and

18 **WHEREAS**, the Palm Beach County Board of County Commissioners desires to
19 prohibit, within the geographic boundaries of Palm Beach County, the practice of sexual
20 orientation or gender identity change efforts on minors by licensed therapists only, including
21 reparative and/or conversion therapy, that have been demonstrated to be harmful to the physical
22 and psychological well-being of lesbian, gay, bisexual, transgender and questioning persons.

23 **NOW, THEREFORE, BE IT ORDAINED BY THE BOARD OF COUNTY**
24 **COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA,** that:

25 **SECTION 1. INTENT:**

26 The intent of this Ordinance is to protect the physical and psychological well-being of
27 minors, including but not limited to lesbian, gay, bisexual, transgender and/or questioning
28 youth, from exposure to the serious harms and risks caused by conversion therapy or reparative
29 therapy by licensed providers, including but not limited to licensed therapists and the
30 unlicensed individuals who perform counseling as part of professional training to become a
31 licensed provider. This Ordinance is an exercise of the County's police power for the benefit

of the public health, safety, and welfare; and its sections are to be liberally construed to accomplish that purpose.

SECTION 2. TITLE:

This Ordinance shall be titled "Prohibition of Conversion Therapy on Minors Ordinance."

SECTION 3. APPLICABILITY:

This Ordinance shall be applicable within the unincorporated areas of Palm Beach County, and in all municipalities that have not adopted an ordinance in conflict. Unless otherwise provided, nothing in this Ordinance shall be construed to relieve any person from compliance with any applicable county or municipal regulations.

SECTION 4. DEFINITIONS:

As used in this Ordinance, unless some other meaning is plainly intended:

Conversion Therapy means the ~~any counseling,~~ practices ~~or treatments that~~ of seeking to change an individual's sexual orientation or gender identity, including but not limited to efforts to change behaviors, gender identity, or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender or sex. Conversion therapy does not include counseling that provides support and assistance to a person undergoing gender transition, or counseling that: provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and ~~, as long as such counseling~~ does not seek to change an individual's sexual orientation or gender identity.

Minor means any person less than eighteen (18) years of age.

Provider means any person who is licensed by the State of Florida to perform counseling pursuant to Chapters 456, 458, 459, 490 or 491 of the Florida Statutes as such chapters may be amended, including but not limited to medical practitioners, osteopathic practitioners, psychologists, psychotherapists, social workers, marriage and family therapists, and licensed counselors, or a person who performs counseling as part of the person's professional training for any of these professions. A provider does not include members of the clergy who are acting in their roles as clergy or pastoral counselors and providing religious counseling to congregants, as long as they do not hold themselves out as operating pursuant to any of the aforementioned Florida Statutes licensures.

1 **SECTION 5. VIOLATIONS:**

2 It shall be unlawful for any Provider to engage in conversion therapy on any minor
3 regardless of whether the Provider receives monetary compensation in exchange for such
4 services.

5 **SECTION 6. PENALTIES:**

6 Pursuant to section 125.69, Florida Statutes, a violation of this ordinance shall be
7 prosecuted in the same manner as misdemeanors are prosecuted. A violation of any provision
8 of this Ordinance shall be punished by a fine of $250.00 for the first violation and $500.00 for
9 each repeat violation.

10 **SECTION 7. ENFORCEMENT**

11 In addition to the penalties set forth in Section 6 of this Ordinance, pursuant to section
12 125.69(4), Florida Statutes, this Ordinance is enforceable by the County's Code Enforcement
13 Officers and by all means provided by law. Additionally, Palm Beach County may choose to
14 enforce this Ordinance by seeking injunctive relief in the Circuit Court of Palm Beach County.

15 **SECTION 8. REPEAL OF LAWS IN CONFLICT:**

16 All local laws and ordinances in conflict with any provision of this Ordinance are
17 hereby repealed to the extent of such conflict.

18 **SECTION 9. SEVERABILITY:**

19 If any section, paragraph, sentence, clause, phrase, or word of this Ordinance is for any
20 reason held by a Court of competent jurisdiction to be unconstitutional, inoperative, or void,
21 such holding shall not affect the remainder of this Ordinance.

22 **SECTION 10. INCLUSION IN THE CODE OF LAWS AND ORDINANCES:**

23 The provisions of this Ordinance shall become and be made a part of the Palm Beach
24 County Code. The sections of this Ordinance may be renumbered or relettered to accomplish
25 such, and the word ordinance may be changed to section, article, or other appropriate word.

26 **SECTION 11. CAPTIONS:**

27 The captions, section headings, and section designations used in this Ordinance are for
28 convenience only and shall have no effect on the interpretation of the provisions of this
29 Ordinance.

30 **SECTION 12. EFFECTIVE DATE:**

31 The provisions of this Ordinance shall become effective upon filing with the
32 Department of State.

1 APPROVED and ADOPTED by the Board of County Commissioners of Palm Beach

2 County, Florida, on this the ____ day of __________________, 20__.

3

4 **SHARON R. BOCK, CLERK**	**PALM BEACH COUNTY, FLORIDA, BY ITS**
5	**BOARD OF COUNTY COMMISSIONERS**
6	
7 **By:**________________________	**By:**________________________
8 **Deputy Clerk**	**Mayor**

9

10 **APPROVED AS TO FORM AND**
11 **LEGAL SUFFICIENCY**
12
13 **By:**________________________
14 **County Attorney**
15
16 **EFFECTIVE DATE: Filed with the Department of State on the ____ day of**

17 **________________, 20____.**

1

ORDINANCE NO. 20__ ______

AN ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, ESTABLISHING THE "PROHIBITION OF CONVERSION THERAPY ON MINORS ORDINANCE"; PROVIDING FOR INTENT; PROVIDING FOR A TITLE; PROVIDING FOR APPLICABILITY; PROVIDING FOR DEFINITIONS; PROVIDING FOR VIOLATIONS; PROVIDING FOR PENALTIES; PROVIDING FOR ENFORCEMENT; PROVIDING FOR REPEAL OF LAWS IN CONFLICT; PROVIDING FOR SEVERABILITY; PROVIDING FOR INCLUSION IN THE CODE OF LAWS AND ORDINANCES; PROVIDING FOR CAPTIONS; AND PROVIDING FOR AN EFFECTIVE DATE.

1 **WHEREAS,** as recognized by major professional associations of mental health
2 practitioners and researchers in the United States and elsewhere for nearly 40 years, being
3 lesbian, gay, bisexual, transgender or gender nonconforming, or questioning (LGBT or
4 LGBTQ) is not a mental disease, disorder, illness, deficiency or shortcoming; and
5 **WHEREAS,** the American Academy of Pediatrics in 1993 published an article in its
6 Journal, Pediatrics, stating: "Therapy directed at specifically changing sexual orientation is
7 contraindicated, since it can provoke guilt and anxiety while having little or no potential for
8 achieving changes in orientation;" and
9 **WHEREAS,** the American Psychiatric Association in December 1998 published its
10 opposition to any psychiatric treatment, including reparative or conversion therapy, which
11 therapy regime is based on the assumption that homosexuality is a mental disorder per se or
12 that a patient should change his or her homosexual orientation; and
13 **WHEREAS,** The American Psychological Association in 2009 issued a resolution on
14 Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts,
15 advising parents, guardians, young people, and their families "to avoid sexual orientation
16 change efforts that portray homosexuality as a mental illness or developmental disorder and to
17 seek psychotherapy, social support, and educational services that provide accurate information
18 on sexual orientation and sexuality, increase family and school support, and reduce rejection of
19 sexual minority youth"; and
20 **WHEREAS,** The American Psychoanalytic Association in June 2012 issued a position
21 statement on conversion therapy efforts, articulating that "As with any societal prejudice, bias
22 against individuals based on actual or perceived sexual orientation, gender identity or gender
23 expression negatively affects mental health, contributing to an enduring sense of stigma and

Attachment 2

1 pervasive self-criticism through the internalization of such prejudice" and that psychoanalytic
2 technique "does not encompass purposeful attempt to 'convert,' 'repair,' change or shift an
3 individual's sexual orientation, gender identity or gender expression," such efforts being
4 inapposite to "fundamental principles of psychoanalytic treatment and often result in
5 substantial psychological pain by reinforcing damaging internalized attitudes"; and
6 **WHEREAS**, the American Academy of Child & Adolescent Psychiatry in 2012
7 published an article in its Journal, Journal of the American Academy of Child and Adolescent
8 Psychiatry, stating that "[c]linicians should be aware that there is no evidence that sexual
9 orientation can be altered through therapy and that attempts to do so may be harmful. There is
10 no empirical evidence adult homosexuality can be prevented if gender nonconforming children
11 are influenced to be more gender conforming. Indeed, there is no medically valid basis for
12 attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may
13 encourage family rejection and undermine self-esteem, connectedness and caring, important
14 protective factors against suicidal ideation and attempts. Given that there is no evidence that
15 efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that
16 they carry the risk of significant harm, such interventions are contraindicated"; and
17 **WHEREAS**, the Pan American Health Organization, a regional office of the World
18 Health Organization, issued a statement in 2012 stating: "These supposed conversion therapies
19 constitute a violation of the ethical principles of health care and violate human rights that are
20 protected by international and regional agreements." The organization also noted that
21 reparative therapies "lack medical justification and represent a serious threat to the health and
22 well-being of affected people;" and
23 **WHEREAS**, in 2014 the American School Counselor Association issued a position
24 statement that states: "It is not the role of the professional school counselor to attempt to
25 change a student's sexual orientation or gender identity. Professional school counselors do not
26 support efforts by licensed mental health professionals to change a student's sexual orientation
27 or gender as these practices have been proven ineffective and harmful"; and
28 **WHEREAS**, a 2015 report of the Substance Abuse and Mental Health Services
29 Administration, a division of the U.S. Department of Health and Human Services, "Ending
30 Conversion Therapy: Supporting and Affirming LGBTQ Youth" further reiterates based on
31 scientific literature that conversion therapy efforts to change an individual's sexual orientation,
32 gender identity, or gender expression, is a practice not supported by credible evidence and has

1 been disavowed by behavioral health experts and associations; perpetuates outdated views of
2 gender roles and identities, and negative stereotypes; and may put young people at risk of
3 serious harm. The report recognizes that same-gender sexual orientation (including identity,
4 behavior, and attraction) is part of the normal spectrum of human diversity and does not
5 constitute a "mental disorder; and
6 **WHEREAS**, the American College of Physicians wrote a position paper in 2015
7 opposing the use of "conversion," "reorientation," or "reparative" therapy for the treatment of
8 LGBT persons, stating that "[a]vailable research does not support the use of reparative therapy
9 as an effective method in the treatment of LGBT persons. Evidence shows that the practice
10 may actually cause emotional or physical harm to LGBT individuals, particularly adolescents
11 or young persons"; and
12 **WHEREAS**, two federal appeals courts found that a prohibition of Sexual Orientation
13 Change Efforts (SOCE) does not violate first amendment rights and noted that the subject laws
14 only required mental health providers who wish to engage in practices that seek to change a
15 minor's sexual orientation either to wait until the minor turns 18 or be subject to professional
16 discipline, leaving mental health providers free to discuss or recommend treatment and to
17 express their views on any topic; and
18 **WHEREAS**, Palm Beach County does not intend to prevent mental health providers
19 from speaking to the public about SOCE; expressing their views to patients; recommending
20 SOCE to patients; administering SOCE to any person who is 18 years of age or older; or
21 referring minors to unlicensed counselors, such as religious leaders. This Ordinance does not
22 prevent unlicensed providers, such as religious leaders, from administering SOCE to children
23 or adults; nor does it prevent minors from seeking SOCE from mental health providers in other
24 political subdivisions outside of Palm Beach County, Florida; and
25 **WHEREAS**, Palm Beach County has a compelling interest in protecting the physical
26 and psychological well-being of minors, including but not limited to lesbian, gay, bisexual,
27 transgender and questioning youth, and in protecting its minors against exposure to serious
28 harms caused by sexual orientation and gender identity change efforts; and
29 **WHEREAS**, the Palm Beach County Board of County Commissioners hereby finds the
30 overwhelming research demonstrating that sexual orientation and gender identity change efforts
31 can pose critical health risks to lesbian, gay, bisexual, transgender or questioning persons, and

1 that being lesbian, gay, bisexual, transgender or questioning is not a mental disease, mental
2 disorder, mental illness, deficiency, or shortcoming; and
3 **WHEREAS**, the Palm Beach County Board of County Commissioners finds minors
4 receiving treatment from licensed therapists in Palm Beach County who may be subject to
5 conversion or reparative therapy are not effectively protected by other means, including, but
6 not limited to, other state statutes, local ordinances, or federal legislation; and
7 **WHEREAS**, the Palm Beach County Board of County Commissioners desires to
8 prohibit, within the geographic boundaries of Palm Beach County, the practice of sexual
9 orientation or gender identity change efforts on minors by licensed therapists only, including
10 reparative and/or conversion therapy, that have been demonstrated to be harmful to the physical
11 and psychological well-being of lesbian, gay, bisexual, transgender and questioning persons.
12 **NOW, THEREFORE, BE IT ORDAINED BY THE BOARD OF COUNTY**
13 **COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA,** that:
14 **SECTION 1. INTENT:**
15 The intent of this Ordinance is to protect the physical and psychological well-being of
16 minors, including but not limited to lesbian, gay, bisexual, transgender and/or questioning
17 youth, from exposure to the serious harms and risks caused by conversion therapy or reparative
18 therapy by licensed providers, including but not limited to licensed therapists and the
19 unlicensed individuals who perform counseling as part of professional training to become a
20 licensed provider. This Ordinance is an exercise of the County's police power for the benefit
21 of the public health, safety, and welfare; and its sections are to be liberally construed to
22 accomplish that purpose.
23 **SECTION 2. TITLE:**
24 This Ordinance shall be titled "Prohibition of Conversion Therapy on Minors
25 Ordinance."
26 **SECTION 3. APPLICABILITY:**
27 This Ordinance shall be applicable within the unincorporated areas of Palm Beach
28 County, and in all municipalities that have not adopted an ordinance in conflict. Unless
29 otherwise provided, nothing in this Ordinance shall be construed to relieve any person from
30 compliance with any applicable county or municipal regulations.
31 **SECTION 4. DEFINITIONS:**
32 As used in this Ordinance, unless some other meaning is plainly intended:

1 *Conversion Therapy* means the practice of seeking to change an individual's sexual
2 orientation or gender identity, including but not limited to efforts to change behaviors, gender
3 identity, or gender expressions or to eliminate or reduce sexual or romantic attractions or
4 feelings toward individuals of the same gender or sex. Conversion therapy does not include
5 counseling that provides support and assistance to a person undergoing gender transition, or
6 counseling that: provides acceptance, support, and understanding of a person or facilitates a
7 person's coping, social support, and identity exploration and development, including sexual-
8 orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual
9 practices; and does not seek to change an individual's sexual orientation or gender identity.
10 *Minor* means any person less than eighteen (18) years of age.
11 *Provider* means any person who is licensed by the State of Florida to perform
12 counseling pursuant to Chapters 456, 458, 459, 490 or 491 of the Florida Statutes as such
13 chapters may be amended, including but not limited to medical practitioners, osteopathic
14 practitioners, psychologists, psychotherapists, social workers, marriage and family therapists,
15 and licensed counselors, or a person who performs counseling as part of the person's
16 professional training for any of these professions. A provider does not include members of the
17 clergy who are acting in their roles as clergy or pastoral counselors and providing religious
18 counseling to congregants, as long as they do not hold themselves out as operating pursuant to
19 any of the aforementioned Florida Statutes licensures.
20 **SECTION 5. VIOLATIONS:**
21 It shall be unlawful for any Provider to engage in conversion therapy on any minor
22 regardless of whether the Provider receives monetary compensation in exchange for such
23 services.
24 **SECTION 6. PENALTIES:**
25 Pursuant to section 125.69, Florida Statutes, a violation of this ordinance shall be
26 prosecuted in the same manner as misdemeanors are prosecuted. A violation of any provision
27 of this Ordinance shall be punished by a fine of $250.00 for the first violation and $500.00 for
28 each repeat violation.
29 **SECTION 7. ENFORCEMENT**
30 In addition to the penalties set forth in Section 6 of this Ordinance, pursuant to section
31 125.69(4), Florida Statutes, this Ordinance is enforceable by the County's Code Enforcement

1 Officers and by all means provided by law. Additionally, Palm Beach County may choose to
2 enforce this Ordinance by seeking injunctive relief in the Circuit Court of Palm Beach County.
3 **SECTION 8. REPEAL OF LAWS IN CONFLICT:**
4 All local laws and ordinances in conflict with any provision of this Ordinance are
5 hereby repealed to the extent of such conflict.
6 **SECTION 9. SEVERABILITY:**
7 If any section, paragraph, sentence, clause, phrase, or word of this Ordinance is for any
8 reason held by a Court of competent jurisdiction to be unconstitutional, inoperative, or void,
9 such holding shall not affect the remainder of this Ordinance.
10 **SECTION 10. INCLUSION IN THE CODE OF LAWS AND ORDINANCES:**
11 The provisions of this Ordinance shall become and be made a part of the Palm Beach
12 County Code. The sections of this Ordinance may be renumbered or relettered to accomplish
13 such, and the word ordinance may be changed to section, article, or other appropriate word.
14 **SECTION 11. CAPTIONS:**
15 The captions, section headings, and section designations used in this Ordinance are for
16 convenience only and shall have no effect on the interpretation of the provisions of this
17 Ordinance.
18 **SECTION 12. EFFECTIVE DATE:**
19 The provisions of this Ordinance shall become effective upon filing with the
20 Department of State.
21

1 APPROVED and ADOPTED by the Board of County Commissioners of Palm Beach
2 County, Florida, on this the 19th day of December, 2017.

3
4 **SHARON R. BOCK, CLERK**
5
6
7 By: [signature]
8 Deputy Clerk
9
10 **APPROVED AS TO FORM AND**
11 **LEGAL SUFFICIENCY**
12
13 By: [signature]
14 **County Attorney**
15

PALM BEACH COUNTY, FLORIDA, BY ITS BOARD OF COUNTY COMMISSIONERS

By: [signature]
Mayor Melissa McKinlay

16 **EFFECTIVE DATE: Filed with the Department of State on the 21st day of**
17 December, **2017**.

STATE OF FLORIDA, COUNTY OF PALM BEACH
I, SHARON R. BOCK, Clerk and Comptroller certify this to be a true and correct copy of the original filed in my office on December 19, 2017
R-2017-1378
dated at West Palm Beach, FL
By: [signature] Deputy Clerk

No. 19-10604

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ROBERT W. OTTO, PH.D. LMFT, individually and on behalf of his patients, and JULIE H. HAMILTON, PH.D., LMFT, individually and on behalf of her patients,
Plaintiffs–Appellants

v.

CITY OF BOCA RATON, FLORIDA, and
COUNTY OF PALM BEACH, FLORIDA
Defendants–Appellees

On Appeal from the United States District Court
for the Southern District of Florida
In Case No. 9:18-cv-80771-RLR before the Honorable Robin L. Rosenberg

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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.
______________________________________/

DEPOSITION OF ROBERT W. OTTO, PH.D., LMFT

A WITNESS

TAKEN BY THE DEFENDANTS

DATE: AUGUST 29, 2018

TIME: 10:00 A.M. - 4:09 P.M.

1 I N D E X

2 WITNESS PAGE

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1 The deposition of ROBERT W. OTTO, PH.D., LMFT,
2 in the above-entitled and numbered cause was taken
3 before me Angela Connolly, Registered Professional
4 Reporter, taken at Palm Beach County Attorney's Office,
5 300 N. Dixie Highway, Suite 359, West Palm Beach, Palm
6 Beach County, Florida, on the 29th day of August, 2018,
7 pursuant to Notice in said cause for the taking of said
8 deposition on behalf of the Defendants.
9
10
11 APPEARING ON BEHALF OF PLAINTIFFS:
12
LIBERTY COUNSEL
13 BY: HORATIO G. MIHET, ESQUIRE
P.O. BOX 540774
14 ORLANDO, FL 32854
(800) 671-1776
15
16 LIBERTY COUNSEL
BY: ROGER K. GANNAM, ESQUIRE
17 P.O. BOX 540774
JACKSONVILLE, FL 32854
18 (800) 671-1776
19
20
APPEARING ON BEHALF OF CITY OF BOCA RATON:
21
22 WEISS, SEROTA, HELFMAN, COLE & BIERMAN, P.L.
BY: DANIEL L. ABBOTT, ESQUIRE
23 200 EAST BROWARD BOULEVARD, SUITE 1900
FORT LAUDERDALE, FL 33301
24 (954) 763-4242
25

1 APPEARING ON BEHALF OF THE COUNTY OF PALM BEACH:

2 PALM BEACH COUNTY ATTORNEY'S OFFICE
BY: RACHEL FAHEY, ESQUIRE
3 BY: KIM PHAN, ESQUIRE
BY: HELENE HVIZD, ESQUIRE
4 300 N. DIXIE HIGHWAY, SUITE 359
WEST PALM BEACH, FL 33401
5 (561) 355-6337

6

7 ALSO PRESENT:

8 Julie H. Hamilton, Ph.D., LMFT, Plaintiff

9 Dr. Rachel Needle

10 - - - - - - - - - - - - - - - -

11 Thereupon:

12 ROBERT W. OTTO, PH.D., LMFT,

13 Having been first duly sworn by me, was

14 examined and testified as follows:

15 THE WITNESS: I do.

16 DIRECT EXAMINATION

17 BY MR. ABBOTT:

18 Q Would you please state your name for the

19 record, sir?

20 A It's Dr. Robert Otto.

21 Q Dr. Otto, my name is Dan Abbott. I represent

22 the City of Boca Raton in connection with a lawsuit that

23 you have filed. Doctor, have you had your deposition

24 taken before?

25 A Yes, I have.

1 Q And can you give me a sense of about how many
2 times that's occurred?
3 A Two dozen.
4 Q Okay.
5 MR. MIHET: Mr. Abbott, I hate to interrupt,
6 but I need to. I'd like to, for the record, to
7 reflect who all is in the room. And I noticed that
8 some of the folks here are, to my knowledge, not
9 employed by the city or the county, so I'd like to
10 hear the Defendants' position as to why their
11 presence is required or needed here today. Can we
12 do that before we start?
13 MR. ABBOTT: I don't object to that.
14 MR. MIHET: Okay.
15 MR. ABBOTT: My name is Dan Abbott, and I'm
16 the only representative here for the City of Boca
17 Raton.
18 MR. MIHET: Okay.
19 MS. PHAN: I'm Kim Phan on behalf of Palm
20 Beach County.
21 MS. FAHEY: Rachel Fahey on behalf of Palm
22 Beach County. We have with us Dr. Needle who is
23 consulting with the county on this case.
24 MS. HVIZD: And I'm Helene Hvizd, the
25 assistant county attorney for Palm Beach County.

1 MR. MIHET: Okay. For the record, we also
2 have Dr. Julie Hamilton, the Plaintiff; obviously
3 Dr. Robert Otto, the Plaintiff; and then Horatio
4 Mihet and Roger Gannam on behalf of the Plaintiffs.
5 Is she here as an expert consultant or --
6 MS. PHAN: Yes.
7 MR. MIHET: She is? Okay. The Plaintiffs
8 believe that she's going to be a fact witness in
9 the case as well given her involvement in the
10 consideration, enactment, and passage of the
11 legislation; and as such, it would be the
12 Plaintiffs' position that it is not appropriate for
13 her to be here during fact depositions, so we would
14 object to her being here.
15 MS. PHAN: To my knowledge, a deposition is an
16 open proceeding and you can't sequester witnesses.
17 So unless you show us case law saying otherwise, I
18 don't see a legal basis for your position.
19 MR. MIHET: Well, you're not suggesting that
20 we can just invite the public from the street to
21 partake in this proceeding?
22 MS. PHAN: But your reasoning is that because
23 you think she's going to be a fact witness so you
24 want to sequester her, so it's very specific here.
25 We're not talking about open to the public.

1 MR. MIHET: Okay.
2 MS. PHAN: We're talking specifically to her
3 as a fact witness.
4 MR. MIHET: Okay. Well, we have our
5 objections for the record. Rather than debating it
6 now, I think we'll proceed, and we'll determine
7 whether we need to seek additional remedies as we
8 go along.
9 MS. PHAN: Okay.
10 MR. MIHET: Sorry about that.
11 BY MR. ABBOTT:
12 Q No problem. Doctor, given that you've given a
13 deposition a couple of dozen times, you've probably
14 heard a comparable speech from attorneys in the past,
15 but let me bore you again.
16 I'm here to ask you a series of questions
17 about the lawsuit that you have filed, and the court
18 reporter is here to record my questions and your
19 answers. You understand that?
20 A Yes, I do.
21 Q The court reporter is also only able to record
22 our verbal statements, and so she's not able to record
23 things like nods of the head or shakes of the head. So
24 for purposes of the deposition, we'll communicate
25 verbally. Agreed?

1 A Yes, I do.
2 Q If I ask you any question that you don't
3 understand or that's confusing, would you ask me to
4 restate the question?
5 A Yes, I will.
6 Q Okay. And, doctor, this is not a test of
7 endurance of any sort. At any time you want to take a
8 break, you let me know, and we'll take a break.
9 A Yes.
10 Q All right. Doctor, would you please give us
11 the benefit of your educational background?
12 A I have a bachelor's degree from the United
13 States Military Academy in Aerospace Engineering. I
14 have a master's degree and a doctoral degree in family
15 therapy from Nova Southeastern University.
16 Q The bachelor's degree, that's a bachelor of
17 science?
18 A Yes, it is.
19 Q And when did you obtain that degree?
20 A 1991.
21 Q And you have obtained two degrees from Nova
22 Southeastern?
23 A That's correct.
24 Q And what was the first one and when did you
25 obtain it?

1 A It was a master's in family therapy, and that
2 was 2000, to the best of my recollection. And the
3 doctoral degree in family therapy, Ph.D, that was 2010,
4 to the best of my recollection.
5 Q When did you first start practicing
6 psychology?
7 A I don't practice psychology.
8 Q What would you say the field is that you
9 practice in?
10 A I'm a licensed marriage and family therapist,
11 so that would be the field that I practice in.
12 Q When did you first start your professional
13 career as a therapist?
14 A I guess you could go back to the internship
15 that I did as a master's student. There's internship
16 time as part of the doctoral program, and I became a
17 licensed -- a registered intern with the state of
18 Florida at some point before the end of the doctoral
19 program. I couldn't give you the exact date off the top
20 of my head.
21 Q Do you expect that was sometime in calendar
22 year 2009?
23 A I don't have any recollection exactly when
24 that was. You go through a Ph.D and your head is in a
25 fog sometimes.

1 Q Well, let me ask you this: What was the
2 duration of the Ph.D program?
3 A I started that in 2000 -- rolled right out of
4 the master's program in 2000 into the doctoral program.
5 I did the coursework and finished that within
6 two-and-a-half-years, as I recall. And then the
7 dissertation took until 2010 to complete.
8 Somewhere in the middle of that, roughly,
9 would have been when I started -- I don't know.
10 Beginning or middle of that I started as an intern,
11 registered intern with the state. You'd have to get
12 that from the state website if it's still there.
13 Q All right. Were you employed, sir, between
14 2000 and 2010?
15 A Yes, I was.
16 Q And can you tell me who you were employed by
17 and what you were doing?
18 A I had three jobs during that time period. I
19 was employed by Spanish River Counseling Center in Boca
20 Raton, Florida. I was a marriage and family therapist
21 there. I did an internship there. And then when my
22 license was -- after the internship here, I got fully
23 licensed with the state of Florida and have been -- was
24 fully employed from that point on as a licensed
25 therapist.

1 Second job, I served for approximately 18
2 years as an expert witness for Palm Beach County courts
3 in guardianship cases. I'm on the examining committees
4 for incapacity hearings.
5 And the third job, I had a real estate
6 broker's license, and I worked at a few different real
7 estate companies in my area, in Boca.
8 Q Do you hold any professional licenses, sir?
9 A Yes, I do. I'm a licensed marriage and family
10 therapist in the state of Florida. And I'm not sure if
11 it's considered a professional license, I also have a
12 real estate broker's license in the state of Florida.
13 Q And how long have you held the marriage and
14 family therapist license?
15 A Again, that would have been somewhere during
16 the years of the doctoral program; middle, beginning,
17 somewhere in there. I don't recall the date when it
18 went from a registered intern with the state of Florida
19 to fully licensed. It's somewhere in that time period
20 before the 2010 graduation date, as I recall.
21 Q What are the requirements, sir, to obtain a
22 marriage and family therapist license in Florida?
23 A It's a master's level license, so you have to
24 have a master's degree from an accredited program. You
25 have to do an internship which requires a certain number

1 of supervision hours and a certain number of client
2 hours. You have to pass the state licensure exam. As I
3 recall, those are the only requirements.
4 Q Is there a continuing education or renewal
5 process for that license?
6 A I believe that's every two years. I couldn't
7 tell you how many hours it is every two years, but, yes,
8 there's something every two years in that.
9 Q And that every two years, is that a continuing
10 education requirement?
11 A Yes, it is.
12 Q Is there any retesting component for that
13 license?
14 A No, there's not, other than the test at the
15 end of the continuing education to make sure that you
16 have mastered whatever the topic is that you've taken
17 the course for.
18 Q The continuing education requirement is to
19 take a single course?
20 A No. No. I can't remember whether it's 50 or
21 30 hours, but it's multiple hours. It's not one, so
22 you'll have to look it up and find out exactly how many
23 hours that is. I don't recall off the top of my head.
24 Q Okay. And how many hours of credit does a
25 typical course provide?

1 A I don't know. I've seen -- I don't know what
2 typical is, but I've seen them for one or one and a
3 half, three. You'll have to check that out and verify.
4 There's lots of different courses on lots of different
5 topics.
6 Q Okay. And at the conclusion of each course,
7 to gain continuing education credits, you have to pass a
8 proficiency exam?
9 A I can't tell you for all of them, but for the
10 ones that I have taken, at the end of the courses there
11 have been multiple choice tests just to make sure that
12 you actually sat there and did the work.
13 Q If you don't pass the test, do you not gain
14 those continuing education credits?
15 A I would assume so, but I don't know for sure
16 because it's never happened to me, and I don't know
17 anybody that's happened to.
18 Q Have you continuously fulfilled your
19 educational requirements since obtaining your license?
20 A Yes, I have.
21 Q You have continually been licensed in marriage
22 and family -- as a marriage and family therapist in
23 Florida since you first obtained the license?
24 A That's correct.
25 Q Could you please give me the benefit of your

1 employment experience after obtaining that license?
2 A So this would begin after the registered
3 intern when I became a fully licensed marriage and
4 family therapist, okay. So starting at that point, I
5 was employed at Spanish River Counseling Center in Boca
6 Raton, Florida, continuously until somewhere around the
7 beginning of June, end of -- beginning of July, end of
8 June of this year. And at that point I opened a private
9 practice, and I'm in private practice at this point.
10 Q And forgive me if I asked you this before, do
11 you recall when you began your employment at Spanish
12 River?
13 A When you say "employment," are you talking
14 about as a fully licensed marriage and family therapist
15 or as a registered intern?
16 Q Well, why don't you tell me both and then tell
17 me at what point you gained your licensure.
18 MR. MIHET: I'm going to object as asked and
19 answered, but go ahead.
20 THE WITNESS: I don't have the dates off the
21 top of my head. You can check online with the
22 state website. I'm sure they have them posted
23 there under my name. But after the -- after the
24 master's program, I rolled into the doctoral
25 program, and at some point within a few years I

1 started doing an internship at Spanish River
2 Counseling Center. I don't remember the date. It
3 would have been after -- it would have been after
4 2000. And I've been there until June of this year,
5 June/July of this year.
6 BY MR. ABBOTT:
7 Q And what particular counseling did you do at
8 Spanish River?
9 A Help me understand what you're looking for.
10 That's a broad question.
11 Q Okay. I'm just trying to figure out how you
12 filled your workdays there, what you were --
13 A Okay.
14 Q -- doing.
15 A Okay. I understand.
16 I would see individuals or couples or
17 families. A broad variety of topics would come across
18 my couch. And not an exhaustive list, but certainly a
19 representative list would include things like
20 post-traumatic stress, marriage issues, parenting
21 issues, sexual orientation issues, issues with
22 pornography, divorce, recovery from divorce. Again,
23 that's a representative list certainly not exhaustive.
24 Q Is that the same sort of work that you're
25 doing now that you're in private practice?

1 A Yes, it is.
2 Q You have served as an expert witness in
3 guardianship proceedings?
4 A That's correct.
5 Q And have you been retained by particular
6 parties in those proceedings?
7 A I'm on the list that the 15th Circuit has for
8 expert witnesses for incapacity cases. And in those
9 cases the judge appoints a three member panel, and I'm
10 one of the people that is appointed to those panels to
11 go and interview an individual to see what their
12 functional assessment is and make a recommendation to
13 the judge.
14 Q Are those contested proceedings?
15 A Define "contested" for me.
16 Q Well, are there occasions where the individual
17 is contesting whether or not he should be -- he or she
18 should be deemed incompetent and required a guardian?
19 A Yes, I have seen some cases that have that
20 factor.
21 Q And in connection with those guardianship
22 proceedings, do you testify in court or do you just
23 provide a written recommendation to the judge?
24 A Every case has a written recommendation to the
25 judge on the standard format that the court requires I

1 use. At times I am asked to come -- subpoenaed to come
2 and be a witness in a hearing.
3 Q Subpoenaed by one of the parties to the
4 proceeding?
5 A Yes.
6 Q Can you provide me an estimate, sir, for the
7 approximate number of times that you have been appointed
8 as an expert witness in a guardianship proceeding?
9 MR. MIHET: Form.
10 THE WITNESS: Can I answer that?
11 MR. MIHET: Yes.
12 THE WITNESS: Okay. This is -- this is just
13 a -- a wild guess. If I get two cases a month
14 times 12 months, you're at -- let's just round it
15 up to 25 a year, and I've been doing it for 18
16 years, approximately 480 cases -- 450 cases there,
17 if that's what the math is off the top of my head.
18 And, again, that's just a raw guess, but it's a
19 significant number like that.
20 BY MR. ABBOTT:
21 Q And those appointments are made by the court?
22 A Yes, sir.
23 Q Are you -- are you from time to time retained
24 as an expert witness by anybody other than the court?
25 A Yes.

1 Q And tell me how that occurs.
2 A There are times when attorneys that I have met
3 through doing these cases have called me and said
4 something along the lines of "I have a client who thinks
5 that his relative might need a guardianship, but before
6 we go through with the full guardianship procedure and
7 the cost of that and the time of that, we want to hire
8 you to come out and do an assessment to see whether --
9 if you are on this examining committee, would it be
10 reasonable to think that this person needs a guardian,"
11 and I make a recommendation and then they take into
12 their considerations and make a decision whether to go
13 forward with the case or not.
14 Q Have you, sir, ever testified as an expert in
15 court in any capacity other than as a member of the
16 examining committee?
17 MR. MIHET: Form.
18 THE WITNESS: Not that I can recall.
19 BY MR. ABBOTT:
20 Q Has any court ever refused to recognize you as
21 an expert witness?
22 A No, not on -- not on the subject or the topic
23 that I'm working with in the capacity as an examining
24 committee member for guardianship cases.
25 Q Have you ever, sir, practiced marriage and

1 family therapy in any capacity other than at Spanish
2 River and your private practice?
3 A When you say at that, you mean physical
4 location or do you mean where my license is held?
5 Q Well, I mean --
6 A Or employed?
7 Q Right. I mean in your employment capacity.
8 You, for a while, were employed at Spanish River?
9 A Yes. That's correct.
10 Q And now you've opened up your own practice?
11 A That's correct. In addition to that, I did
12 two internships as part of the master's and the doctoral
13 work -- three internships. Two of those were the Family
14 Therapy Clinic at Nova University, which I believe is
15 called Brief Therapy Clinic or something like that, and
16 then one at Sheridan House in Broward County, Florida.
17 Q Have we now covered, sir, all of the -- all of
18 the marriage and family therapy employments that you
19 have had?
20 A Yes, we have.
21 Q Okay. Did you open up your private practice
22 in June or July of this year?
23 A Yes. As I recall, it was the end of June,
24 early July, but I don't have a specific date.
25 Q And where is your business address?

1 A 4400 North Federal Highway, Suite 210, in Boca
2 Raton, Florida 33431.
3 Q And that has remained your business address
4 since you went into private practice?
5 A That's correct.
6 Q Is that business incorporated?
7 A It's an LLC in the state of Florida.
8 Q And what is the name of the LLC?
9 A SDG Counseling, LLC.
10 Q And who is employed by that organization?
11 A Just me at this point, yes.
12 Q There are no other marriage and family
13 therapists employed by that organization?
14 A No.
15 Q And you don't have any support staff or like
16 secretaries?
17 A At this point, no, but I look to expand and do
18 that, yes.
19 Q Are you hoping to expand at your current
20 location or to open up an additional location?
21 A I don't have any plans one way or the other on
22 that.
23 Q Now forgive me, doctor, I'm not a family
24 therapist and I haven't gone to one. Can you give me
25 some sense of how that practice works?

1 First of all, what would be the best thing to
2 call a meeting that you have with a client?
3 A A session.
4 Q Okay. And would it be fair to say that you
5 provide therapy in those sessions?
6 MR. MIHET: Form.
7 THE WITNESS: Yes. I provide therapy for
8 clients in those sessions. When you -- when you're
9 asking that question, I want to make a distinction
10 that the therapy I provide is 100 percent speech
11 and not conduct, and I think that -- I think that
12 it's a dubious constitutional endeavor in the 11th
13 Circuit to equate conduct and speech or speech and
14 conduct.
15 The flow of those sessions is I shake their
16 hand when they arrive, and I open the door for
17 them. We sit down. I rock in my chair a little
18 bit. I write a few notes maybe. I shake their
19 hand when they leave and open the door. Everything
20 else that happens in that hour session is speech.
21 So when you ask me about conducting therapy, in my
22 head, my perspective, it is 100 percent speech.
23 BY MR. ABBOTT:
24 Q Well, let me ask you this: Is therapy a term
25 of art in your profession?

1 MR. MIHET: Form.
2 THE WITNESS: I don't know what "a term of
3 art" means.
4 BY MR. ABBOTT:
5 Q Does the word have a defined meaning in what
6 you do?
7 MR. MIHET: Form.
8 THE WITNESS: I don't know. I don't know if
9 there's some specific definition that's out there
10 that -- it's a general term.
11 BY MR. ABBOTT:
12 Q Well, let me ask you this: What does it mean
13 to be a therapist?
14 A Well, when my client's come and they're asking
15 me to work with them, they're sharing discomfort or
16 challenges in their lives, and they want me to help them
17 walk through those issues in the ways that they deem
18 helpful and productive to reduce the stress -- the
19 distress in their worlds. And so we do that through
20 speaking about those issues. And does that answer your
21 question?
22 Q Well, I'm not sure it does. I have friends
23 from time to time that come by my house and tell me that
24 they're troubled about something, and we talk about it.
25 I gather you would agree that I'm not providing therapy

1 in those -- in those meetings?
2 MR. MIHET: Form.
3 THE WITNESS: Yes, I would agree with that.
4 BY MR. ABBOTT:
5 Q Okay. And so why is what you do different?
6 What makes what you do therapy and what I do not?
7 MR. MIHET: Form.
8 THE WITNESS: Well, number one, you're not
9 licensed with the state of Florida. You've not had
10 the training that I've had. You might have good
11 intentions, but -- but you certainly don't have the
12 expertise that would come with my level of training
13 and experience.
14 BY MR. ABBOTT:
15 Q And tell me, how do your training and -- how
16 does your training and expertise help you do what you
17 do? How does what you know make you behave differently
18 than I do in those sorts of meetings with my friends?
19 MR. MIHET: Form.
20 THE WITNESS: Sure. That's a really big
21 answer that took many years of coursework and
22 dissertation work to delve into, so my answer is
23 certainly not going to be able to cover all of
24 that. I can give you a piece of that. And that
25 would be that I understand that I cannot change my

1 clients, that my clients can choose to change, and
2 that it would be inappropriate for me to impose my
3 views on my clients, but it would be appropriate to
4 me to be client-centered and client-directed and
5 client-driven in my therapy.
6 So if my client comes in with an issue that is
7 providing discomfort for them, and distress for
8 them, and that client wants to experience some
9 relief from that, then I would be obligated to help
10 that client to get to the place where there is some
11 relief from that discomfort and distress.
12 BY MR. ABBOTT:
13 Q Okay. So I think I understand at least one of
14 the things that you don't do. I'm still not sure I have
15 a handle on what you do do that nonprofessionals do when
16 they're just speaking with troubled people.
17 A Well, I could give you --
18 MR. MIHET: Form.
19 THE WITNESS: Sorry.
20 MR. MIHET: Form. Is there a question?
21 BY MR. ABBOTT:
22 Q Yes, and I believe the witness was beginning
23 to answer.
24 A I might have some good ideas about, you know,
25 how to write a will. You might want to leave your stuff

1 to your kids, you know, but I'm not an attorney, you
2 are. There's going to be limits on what I'm able to
3 advise people just because I have common sense versus
4 education.
5 You might have common sense in something, but
6 the education provides me a different perspective,
7 perhaps, than -- than what someone else might have.
8 That doesn't nullify, you know, all the ideas that
9 somebody's not licensed might have, and certainly people
10 do gain relief in talking with friends, so I wouldn't --
11 I wouldn't minimize that, but as someone who's been
12 trained to work with people and walk them through like
13 grief, for example, or post-traumatic distress, how do
14 you handle post-traumatic stress? That's a big topic
15 that takes some training and some experience and
16 expertise on, and so there are some specific things like
17 that.
18 I'm not sure that answers your question, but
19 that's kind of my thoughts.
20 Q Okay. You have a doctorate?
21 A Yes, I do. It's a Ph.D.
22 Q A Ph.D. You have scientific training and
23 licensing?
24 MR. MIHET: Form.
25 THE WITNESS: I'm sorry, I didn't hear the

1 question.
2 BY MR. ABBOTT:
3 Q You have scientific training?
4 A I don't know what scientific training means.
5 Q All right. Well, is marriage and family
6 therapy a science?
7 MR. MIHET: Form.
8 THE WITNESS: Okay. The marriage and family
9 therapy, the theories, are based upon research,
10 outcomes, and what does and doesn't help clients
11 according to research and outcome-based studies.
12 BY MR. ABBOTT:
13 Q There are means and methods in how a therapist
14 practices his profession?
15 MR. MIHET: Form.
16 THE WITNESS: What do you mean by "means and
17 methods"?
18 BY MR. ABBOTT:
19 Q Well, I'm just trying to, again, figure out --
20 and I think you've let me know, and I don't disagree
21 with you, that you have training that I don't have. So
22 you are prepared to provide therapy in a way that I'm
23 not, true?
24 A Yes.
25 Q And I'm trying to get a handle on what that

1 is. What would you call what you know and what you do
2 versus what I know and what I would do?
3 A Okay.
4 MR. MIHET: Stop. Form, asked and answered.
5 Go ahead.
6 THE WITNESS: Okay. So in the coursework that
7 I had at Nova University, we studied marriage and
8 family therapy. We studied cognitive, behavioral.
9 We studied solution-focused family therapy. We
10 studied client and client-based family therapy, but
11 many other different theories of how family therapy
12 can work that have been a part of the development
13 in this field for the last many decades.
14 So if you're asking about science, there's a
15 piece of each one of those theories that would be
16 rooted in science and have proponents for strengths
17 and limitations. Does that answer your question?
18 BY MR. ABBOTT:
19 Q Well, let me use your example. You have
20 provided therapy to patients who are suffering from
21 post-traumatic stress?
22 A Yes.
23 Q So why don't we just use that as an example.
24 What do you do in a therapy session for a patient who
25 has post-traumatic stress? What do you do to try to

1 help them?
2 MR. MIHET: Form.
3 THE WITNESS: What you're asking me there is
4 for a simple answer on a complex topic. Every
5 client that comes through my door -- again, using
6 that example of post-traumatic stress, every client
7 that comes through my door dealing with that
8 particular issue is a different conversation, is a
9 different speech, a different talk back and forth,
10 so there's not a one-size-fits-all to that, okay.
11 If you're looking for some general principles
12 or general parts that would be involved in each of
13 those different conversations and speeches -- when
14 I say "speech," I mean my speech and my client's
15 speech, okay. For post-traumatic stress, again
16 using that example, I would go through a checklist
17 and these are common symptoms for post-traumatic
18 stress.
19 I would share with them that post-traumatic
20 stress actually shows up on a brain scan. It's as
21 clear as a broken bone shows up on an X-ray, and
22 that provides some relief when people realize
23 they're not crazy.
24 I would talk them through and discuss with
25 them the causes of their post-traumatic stress and

1 how it's a normal person's reaction to a completely
2 abnormal situation. I would talk them through how
3 that impacts people's relationships with others,
4 and we might get into topics such as secondary PTSD
5 with family members.
6 I would talk with them about normal responses
7 in relationships, normal responses in people, and
8 whether that's physical responses or emotional
9 responses. Usually the emotional response is what
10 brings them through my door or the relationship
11 responses bring them through my door. And to be
12 able to normalize that, to understand from their
13 perspective what it's like, again, "If this is
14 providing you distress, would you like it to be
15 different, you know?" And so working with the
16 client-centered approach on that.
17 Those would be some of the key points that I
18 would have with any client on post-traumatic
19 stress.
20 BY MR. ABBOTT:
21 Q All right. So let me see if I've got those in
22 order. One of things you do is you make a diagnosis?
23 MR. MIHET: Objection. Form.
24 THE WITNESS: When you talk about making a
25 diagnosis, I don't -- I don't make a diagnosis.

1 I'll make an assessment of what's going on. I am
2 not -- with my license, I do not believe I'm able
3 to make a formal diagnosis of something like a
4 psychiatrist would make, so I'm not going to
5 diagnose somebody as being bipolar or something
6 like that.
7 I have not found that labels are particularly
8 helpful in my practice most of the time, so I would
9 make an assessment that you're -- you know, if
10 you've got many of these things on this checklist,
11 let's talk about these things and the root causes
12 of these issues and some solutions for those
13 issues.
14 BY MR. ABBOTT:
15 Q All right. What do you mean by "an
16 assessment" and how is that different than a diagnosis?
17 A Well, if they're coming in and they're talking
18 about a combat experience that they've had or a
19 traumatic experience as a police officer, as a first
20 responder, or sexual abuse, that would trigger me to
21 pull out my post-traumatic stress checklist. And if
22 they checked off some things on that list, then I would
23 be inclined to have conversations about that topic with
24 them.
25 Q All right. So while you might not make a

1 diagnosis of post-traumatic stress, you would begin
2 treating your patient as if they had post-traumatic
3 stress?
4 MR. MIHET: Objection. Form.
5 THE WITNESS: I would be -- I would be
6 addressing the issues that they're distressed about
7 and help them understand that those are common with
8 people who experience trauma.
9 BY MR. ABBOTT:
10 Q Okay. Post-traumatic stress would show on a
11 brain scan?
12 A That's correct.
13 Q In your practice, do you either order or
14 recommend that your patients from time to time get a
15 medical exam?
16 A I work hand-in-hand with medical
17 professionals, doctors and psychiatrists, in a team
18 effort to help my clients.
19 Q So in the example that we're talking about, if
20 you had a patient that you were able to check off a
21 number of symptoms of post-traumatic stress, do you,
22 from time to time, recommend that your patient get a
23 brain scan?
24 A Just for clarification, I refer to my clients
25 as clients, not patients. Medical doctors usually refer

1 to them as patients.
2 So with my clients, I have talked about brain
3 scans with them, but at this point it's, I think, about
4 $3,000 and if you have the -- if I have the information
5 and they have the information on a checklist and they
6 see they checked off 80 percent of the things that are
7 common with people who have experienced trauma, usually
8 they don't say, "Gosh, I want to go see this on a brain
9 scan. Let me pay $3,000." They have the information
10 they need at that point. But we certainly talk about
11 how that shows, and I'll perhaps show them pictures of
12 brain scans of people with PTSD just to validate that so
13 they can see it in a concrete way.
14 There was something else you asked about
15 working with doctors. Is that -- did I answer your
16 question or is there another piece to that?
17 Q I think I'm good. Thanks.
18 MR. MIHET: He'll let you know if you didn't
19 answer his question to his satisfaction.
20 THE WITNESS: Okay. Got it.
21 BY MR. ABBOTT:
22 Q And the last thing I wrote down on the list
23 that you gave me in speaking about post-traumatic stress
24 is you will let your client know what the normal
25 responses are to traumatic events. Do I remember that

1 correctly?
2 A Yes.
3 Q And you do that why? Is that a part of -- is
4 that a part of the treatment? You're hoping that that
5 process will help your client address their concerns?
6 MR. MIHET: Form.
7 THE WITNESS: Again, using this specific
8 example of post-traumatic stress, there are certain
9 common responses that people have.
10 The example that I will use with my clients
11 oftentimes is "This is a heavy wooden door and if I
12 open it and put my hand in it and you slam the door
13 as hard as you can, what will happen?" And they
14 look at me and they say, "Well, your hand would
15 break and you would be in a lot of pain and you'd
16 scream and cry."
17 "Would that happen if we did it to your hand?"
18 And they'd say, "Yes." I'd say "That's a normal
19 person's response to a completely abnormal
20 situation."
21 When people experience trauma, there are
22 certain normal responses that they have, and they
23 are common to all trauma. And normal people
24 experience these things, and that helps clients to
25 understand that they're actually normal and they're

1 not bad and they're not wrong and they're not
2 deficient and they're not in any way lacking or
3 lesser in value because they're experiencing this
4 discomfort.
5 BY MR. ABBOTT:
6 Q And the thought in your profession is if the
7 client realizes that they have had a normal response,
8 that will help them deal with what's troubling them?
9 MR. MIHET: Form.
10 THE WITNESS: I'm not sure I would make that
11 such a sweeping statement. It would be a part of
12 helping them deal with what's going on, but just
13 that realization doesn't change everything. It
14 might bring about another conversation, another
15 level of conversation with them.
16 BY MR. ABBOTT:
17 Q So what else do you do to then help your
18 patient?
19 MR. MIHET: Form.
20 BY MR. ABBOTT:
21 Q I think you've told me -- and we're talking
22 about post-traumatic stress symptoms. So you've got a
23 hypothetical client. They're exhibiting signs of
24 post-traumatic stress, and so you make an assessment and
25 you let the client know that their reaction to a

1 traumatic event is normal. Yes?
2 A Yes.
3 Q And what else do you do to help your client
4 deal with the trauma that has caused them to seek your
5 help?
6 A Depending on the level of discomfort that
7 they're experiencing, we may continue to talk about
8 their anxieties and their behavior changes and their
9 emotional responses and how to deal with those.
10 I will also work with clients with something
11 called EMDR, which has proven to be very beneficial for
12 clients with post-traumatic stress issues.
13 Q You will talk to the client about their
14 anxieties, true?
15 A Yes.
16 Q And is that -- how does that help the client?
17 A Well, if they understand their anxieties and
18 they understand what's causing those anxieties and how
19 those anxieties are -- and "anxieties," I'm using that
20 as a broad generalization of a term, not --
21 Okay, a discomfort. We're talking about their
22 discomforts and they understand how those discomforts
23 will affect and are affecting their relationships with
24 their -- with a spouse, with children, with co-workers,
25 and being able to understand that that discomfort that

1 they're experiencing is perhaps rooted in a normal
2 response to trauma, then that can help them understand
3 how to -- how to bring about some changes in their lives
4 and see those situations differently.
5 Q The next thing I think you told me is that you
6 might help your clients undergo behavioral changes?
7 A If there are things that they're doing that
8 they would like to be different. For example,
9 responding with -- in anger. Short fuse, rage, those
10 are normal responses to trauma. We would talk about how
11 to have other responses in those situations.
12 Q Is it fair to call that phase of what you do
13 treatment?
14 MR. MIHET: Form.
15 THE WITNESS: Yes, I guess so.
16 BY MR. ABBOTT:
17 Q And can you explain to me how you are more
18 qualified to effect those behavioral changes than a
19 nonprofessional?
20 A Sure.
21 MR. MIHET: Objection. Form, asked and
22 answered.
23 THE WITNESS: Sure. How am I more qualified
24 to do that than someone else?
25 BY MR. ABBOTT:

1 Q Yes, sir.
2 A When you say someone -- someone like you?
3 Q Yes, sir.
4 A Okay. Because I have met the state's
5 requirements for education and training and licensure to
6 be able to do that, and the state has determined what
7 those requirements are.
8 Q And what are the methods that you are familiar
9 with that I'm not that help you in effecting those
10 behavioral changes?
11 MR. MIHET: Form, asked and answered.
12 THE WITNESS: You're asking me to boil down
13 many years of graduate school into one answer here.
14 I don't know how to do that.
15 BY MR. ABBOTT:
16 Q Okay. There are a myriad of things that
17 you're aware of that you use to help effect behavioral
18 changes that I'm not familiar with, is that what you're
19 telling me?
20 A I have learned some things in the classwork at
21 Nova Southeastern University and my studies and my
22 continuing education that has given me the ability to
23 help people in dealing with the stress in their lives.
24 Q Okay.
25 A And if you had taken that same classwork and

1 that same continuing education and the same licensure, I
2 imagine you would have the same insights as I have at
3 this point.
4 Q I think, doctor, you perhaps overestimate me.
5 So let me talk about the example that we've
6 been talking about. So you've got -- you've got a
7 client who is exhibiting signs of post-traumatic stress
8 disorder and they are responding by acting out in anger.
9 Can you let me know some of the methods that you use to
10 help your client not respond in an angry way?
11 MR. MIHET: Form.
12 THE WITNESS: Well, we would talk about what
13 situations are triggers for those outbursts. We
14 would talk about how to avoid those situations or
15 have a different response in those situations. We
16 would look for triggers.
17 BY MR. ABBOTT:
18 Q And those are things that you have been
19 trained to do?
20 A Yes.
21 Q And you apply that training with your clients?
22 A Yes. That's correct.
23 Q Now, doctor, you made a point earlier on that
24 what you do in your practice is speech.
25 A Yes.

1 Q And I think you told me only speech.
2 A I didn't say only speech. I said that when I
3 greet people at the door, I speak. Most of what we do
4 in the office is speak, is talk, uh-huh.
5 Q Okay. Is there anything that you do that's
6 not speech? Let me break that down. Do you have any
7 medical instruments that you use in your office?
8 A Okay. So with post-traumatic stress, I have
9 been trained for EMDR. And that is a device that
10 somebody holds in their hands and it's a bilateral
11 stimulation of the brain, left side/right side, and we
12 talk. They talk, I listen, while they're -- while
13 they're holding those little buzzers in their hand.
14 Q Are those called EMDR devices or buzzers or
15 what can I call them?
16 A That's a good generic title for it, either one
17 of those.
18 Q Okay. Are there any other medical instruments
19 that you use in your office?
20 A No, sir.
21 Q Is there anything else tangible that you use
22 in your office? Do you have photographs that you use?
23 A I have a white board I write on. Again, that
24 would be written speech in my opinion.
25 Q That white board is --

1 A Dry-erase. It's a dry-erase board.
2 Q Fair enough. I wasn't even going to bug you
3 about that. I was going to ask you this: That white
4 board or that dry-erase board is usually blank when the
5 session begins?
6 A Yes, it is.
7 Q Okay. And the things you write on the white
8 board are what? Things that your client may have said
9 that you find to be of significance?
10 A Sometimes.
11 Q And what else might you write on there, on
12 your white board?
13 A Well, they might write on it also.
14 Q Okay.
15 A Okay. And so, again, it's their speech and
16 it's my speech. I might write some key points for them
17 to see. I might --
18 An hour is a long time to sit and talk with
19 somebody. If you want to keep track of key ideas,
20 oftentimes clients will take notes on paper or we'll
21 write things down so we don't lose what we talked about
22 at the beginning of the session by the end of the
23 session so they can see, you know, the progression of
24 the conversation.
25 Q Okay. Other than the dry-erase board and the

1 EMDR device, is there anything else tangible that you
2 use in your office?
3 MR. MIHET: Form.
4 THE WITNESS: I have a laptop. I may show a
5 picture on the laptop.
6 BY MR. ABBOTT:
7 Q And those are -- I am technologically
8 primitive. Those are pictures that are a part of the
9 drive of the computer or those are pictures you will
10 find by doing an Internet search?
11 A An Internet search.
12 Q Okay. Anything else that you -- tangible that
13 you use in your office?
14 A Tissues, lots of them.
15 Q And, doctor, are you an unusual marriage and
16 family therapist in that regard? In other words, are
17 there others in your profession that routinely use
18 tangible devices that we have not discussed here today?
19 MR. MIHET: Form.
20 THE WITNESS: I can only speak to the
21 professionals that I have known at the counseling
22 center where I worked, at the places where I've
23 done internships. And other than EMDR devices, I
24 don't think there's -- and the white boards, I
25 don't think there's anything else that anybody else

1 would use that I have seen --
2 BY MR. ABBOTT:
3 Q Okay.
4 A -- but I can't speak for everybody across the
5 profession.
6 Q Sure.
7 A I can only tell you what I have seen.
8 Q And is that consistent with your training? By
9 which I mean the following: Are there -- were there
10 devices that were recommended to you or that you were
11 taught in your training that you have just on your own
12 opted not to use?
13 A No.
14 Q And I think before -- I think you told me
15 this, forgive me, you deem all of those things that
16 you're doing and using in the office to be speech?
17 A I didn't say that.
18 MR. MIHET: Objection. Mischaracterizes his
19 testimony.
20 BY MR. ABBOTT:
21 Q All right. Forgive me. I misspoke then.
22 Would you categorize the things that we have
23 discussed here, the things that you do in your
24 profession, as all being speech?
25 MR. MIHET: Form, asked and answered.

1 THE WITNESS: So holding those EMDR devices in
2 their hand would not be speech. While we're
3 talking, while they're talking with me while
4 they're doing that, that is speech. You can do
5 some research on what that does.
6 The computer, showing a picture of a brain
7 scan on a computer is an example for PTSD. I'm not
8 an attorney, you have to find out whether that's
9 speech. Let the attorneys argue that one out. But
10 those are really -- writing on the white board, I
11 would consider that speech. Talking, a lot of
12 talking. Crying's not speech, but I mean I guess
13 you could pass a tissue box.
14 BY MR. ABBOTT:
15 Q Right. Would you agree then it's really the
16 nature of your profession that you do -- you do what you
17 do? Your profession is accomplished through speech?
18 A Yes. That's correct.
19 Q Is part of your practice, doctor, engaged in
20 efforts to change a client's sexual orientation?
21 MR. MIHET: Form.
22 THE WITNESS: I told you earlier that I can't
23 change any client.
24 BY MR. ABBOTT:
25 Q All right. Is it a part of your practice to

1 attempt to change any client's sexual orientation?
2 MR. MIHET: Form.
3 THE WITNESS: I can't change any client. My
4 client's come to me with issues of distress that
5 they want to work on, and I will talk with them
6 about those issues and about alleviating their
7 stress. Or if they have a conflict between their
8 sincerely held religious beliefs and some other
9 aspect of their life, be that sexual or not, we'll
10 talk about those incongruities and how to make
11 sense of those and how to decrease their anxiety
12 and discomfort that comes from that.
13 And, again, this is client-centered and
14 client-directed with clients' goals. So when you
15 ask me about trying to change somebody, I am not
16 trying to change anybody on anything. These are
17 client issues that clients want to seek change on,
18 and they come asking for assistance as they walk
19 through that journey, and we talk about that
20 process in speech.
21 BY MR. ABBOTT:
22 Q All right. Well, let me make sure I
23 understand. And I didn't mean to suggest that anything
24 you do is against a client's will.
25 So let's assume that you have a client that

1 expresses a desire to change his or her sexual
2 orientation. Do you then undergo efforts in an attempt
3 to, in fact, change the client's sexual orientation?
4 MR. MIHET: Form.
5 THE WITNESS: I've already said I can't do
6 that. That's like trying to say you go to the
7 doctor and here, "I'd like to be nine feet tall.
8 Would you try to change me?" That's impossible.
9 The doctor is not going to change you to do that.
10 So, I cannot change a client to do that.
11 You can ask that in lots of different ways,
12 but the answer is always going to be "I cannot
13 change a client."
14 BY MR. ABBOTT:
15 Q Okay. In an equally clear way, would you
16 agree that that being the case, you don't attempt to
17 change a client's sexual orientation?
18 A Yes. With the caveat that I don't want the
19 way you asked that question to imply that, whether or
20 not I attempt to do it or not, that is something that
21 could be attempted or that I could do if I did attempt
22 it. Okay.
23 Q I understand.
24 A I don't attempt it. I cannot do it even if I
25 were to attempt it.

1 Q Understood. But you understand people --
2 people sometimes attempt things that are unlikely to be
3 successful. I can go home and attempt --
4 A I did not attempt it, and I cannot do it.
5 Q Very good, sir.
6 Much in the way that I can attempt to go home
7 and dunk a basketball even though I can't do it, right?
8 So you understand the distinction I'm drawing?
9 A Yes, I do.
10 Q And you made it clear that you neither can nor
11 do you attempt to change --
12 A That's correct.
13 Q -- sexual orientation?
14 A That is correct.
15 Q All right. So what's the best way to describe
16 what you do in terms of clients with sexual orientation
17 issues? You don't change the orientation or try to
18 change the orientation. What do you do in that regard?
19 A Well, if I have a client who comes in --
20 that's a real broad question. There are lots of --
21 Can you narrow that down? There's a lot of
22 clients who might be coming in, hypothetically, to deal
23 with that topic that you've just mentioned. Focus me in
24 a little bit on that.
25 Q Well, all right. Maybe it would be better for

1 you to answer by way of an example rather than as a
2 universal. I'm just not -- I just want to get a handle
3 on what it is you do or what you might do if you have a
4 client that has sexual orientation issues.
5 A Okay. Are you talking about a minor? Are you
6 talking about an adult?
7 Q Well, let's talk about minors.
8 A Okay. So if I have a minor who comes in, the
9 parents bring the client in. I have consent forms that
10 they sign. We talk about goals for therapy. That
11 conversation includes the parents and the child. We
12 talk about why they came, what's the distress they're
13 experiencing that they would like to be different. We
14 would talk about how it's affecting their life. What
15 are the root causes of that discomfort? Is there some
16 incongruity between what they believe and what they
17 feel?
18 And in this regard, since we're talking about
19 minors, if they don't want to participate in a
20 conversation, they keep their mouths closed, end of
21 story, game's over, let's go home. So I can't coerce
22 somebody to even participate in a conversation, okay.
23 And if a client comes in and is willing to participate
24 in a conversation, is asking me to participate in that
25 conversation about how to handle these points of

1 dissonance in their lives, then we'll talk about those
2 things. And, again, all of that is speech. All of that
3 is talk.
4 Q Okay.
5 MR. MIHET: Mr. Abbott, we've been at it for
6 about an hour. When it's convenient for you, I
7 could use a restroom break.
8 MR. ABBOTT: Any time is convenient, so have
9 at it.
10 (Thereupon, a short break was taken from 10:56
11 a.m. to 11:03 a.m.)
12 BY MR. ABBOTT:
13 Q Doctor, I think when we left off we were
14 talking about patients who come to see you with regard
15 to sexual orientation issues. I think the last thing
16 that -- well, I'm not sure it was the last thing, but
17 you mentioned that you can't make a client speak.
18 A That's correct.
19 Q And does that happen or has that happened?
20 Have you had a minor client come to see you about sexual
21 orientation issues and then that client just wouldn't
22 communicate with you?
23 A I have had minor clients who didn't want to
24 communicate about that topic with me.
25 Q Okay.

1 A I've had other minor clients who got up and
2 walked out of the room, but not on that topic.
3 Q So when we started to talk about minors, you
4 said a few things. You said when you have a minor
5 client, that the parents bring the child in to see you?
6 A Well, if they have a driver's license, they
7 can come themselves, but the first time the parents do
8 bring them because it is helpful to -- well, the parents
9 sign the consent forms, the parents pay.
10 The goals that the clients set are often set
11 in conjunction with parents and conversations with
12 parents, and so it's helpful to get everybody in the
13 room oftentimes upfront for a few minutes and say "What
14 are the goals that we have that we want to work
15 towards?" And that's usually a collaborative process
16 that involves all parties.
17 Q Is that a legal requirement to the best of
18 your knowledge?
19 MR. MIHET: Objection. Form.
20 THE WITNESS: I don't know whether it's -- I
21 know it's in the code -- I believe it's in the code
22 of ethics for the different professional
23 organizations, but I don't know if it's a legal
24 requirement. We do it. I do it.
25 BY MR. ABBOTT:

1 Q Okay. You require parents to sign consent
2 forms?
3 A I have always required parents to sign consent
4 forms when working with children, yes.
5 Q And you will not -- you will not treat a
6 client whose parent has not signed a consent form?
7 A In the past I have not. I believe there's a
8 Florida Statute that says if clients are 13 or older,
9 then they can -- they can give limited consent. I
10 don't -- I can't tell you whether that would come into
11 play in my practice in the future or not, but I believe
12 that's out there.
13 Q Okay. At least as of today, you have not
14 treated a client whose parents -- treated a minor client
15 whose parent did not sign a consent form?
16 A That's correct.
17 Q I think the next thing you told me is that
18 parents pay?
19 A That's correct.
20 Q That's an important part of your practice?
21 A Yes, sir.
22 Q And what if you had a hypothetical minor
23 client who had the means and willingness to pay, would
24 you still require a parent to sign the consent form?
25 A That's a pretty broad hypothetical. Again, I

1 believe that Florida Statute says that if they're 13 or
2 older, then they can provide some -- they can consent.
3 And there are some limitations in that statute that
4 would allow a certain amount or level of care.
5 At this point in my practice I want to work
6 with parents because family therapy takes in the context
7 the family system. And if that minor is living in a
8 house with parents, it would be helpful for everybody in
9 the house to understand what's going on. And again, I'm
10 generally speaking, and so I have not found it
11 beneficial to date to provide counseling for minors
12 without parental consent even if they would fall under
13 that Florida Statute that would give me permission to do
14 so.
15 Q I hope you forgive me, doctor. I am not
16 familiar with that Florida Statute. Do you happen to
17 know it by number?
18 A No, I don't.
19 Q And can you tell me any more about it other
20 than it allows minors 13 years old or older to consent
21 to therapy? Is it therapy in particular?
22 A I would say the only thing I remember about
23 it, other than what I've just said, is I believe one of
24 the limitations is twice a week. You'll have to do the
25 research and find it.

1 Q That's fine.
2 A I've not used it in my practice, so it's not
3 something that I have on the tip of my tongue.
4 Q Fair enough.
5 And I think you told me that in your practice
6 the parents help set the goals?
7 MR. MIHET: Form.
8 THE WITNESS: Yes, sir. That's correct.
9 BY MR. ABBOTT:
10 Q And how does that happen practically? Does
11 the initial session with a minor client necessarily
12 begin with both the minor client and the -- and a
13 parent?
14 A Again, that's not a one-size-fits-all answer.
15 I have had clients where the parent might come in first
16 and give some background information and then the minor
17 comes in. I've had clients where the minor wanted to
18 come in first and talk, and I've had clients where we
19 all sit down together and have that conversation
20 together. Again, it's client-directed. What are they
21 comfortable with, I'll work with that.
22 Q For each of the minor clients you have had,
23 have you had meetings with both the minor and a parent
24 to help set goals for the therapy?
25 A I've seen a lot of minors over the years. Are

1 you just focusing in on the sexual question here at hand
2 that this ordinance covers or are you focusing on all of
3 my minor clients across the board?
4 Q Fair question. Let me start more generally.
5 For all of your minor clients, do you -- in
6 order to set goals for the therapy, do you take input
7 from both the minor and a parent?
8 MR. MIHET: Form.
9 THE WITNESS: Yes.
10 BY MR. ABBOTT:
11 Q Have you ever had a prospective minor client
12 who didn't want you to meet with his or her parents?
13 A When you say want me to meet with them, give
14 me some details on what you mean by that.
15 Q Sure. I think you just told me that when a
16 minor client comes in, that in order to set the goals
17 for the therapy, you take input from both the minor and
18 from a parent.
19 A Yes. That's correct.
20 Q Have you ever had a minor client who has said
21 "These are my goals from the therapy and you don't need
22 to talk to my parents about it"?
23 A No, I haven't had that, but I've had clients
24 who said "I have different goals than my parents."
25 Q And what do you do when that occurs? What

1 happens if the minor and the parents have different
2 goals?
3 A I'll give you an example of a teenager that --
4 again, that's broad because there's a lot of different
5 issues and a lot of different aged type of clients, but
6 again, a teenager had different goals than the parents,
7 and I mean if the teenager is not going to talk about
8 what the parents want to talk about, you know, I can't
9 force the teenager to do that. We can talk -- "What's
10 interesting to you? Let's talk about what's interesting
11 to you." And we'll go with whatever the teenager's
12 goals are at that point and talk about that.
13 Oftentimes those conversations kind of turn
14 back on "Where's the disconnect between you and your
15 parents? Obviously you're living under their roof. If
16 there's some level of discomfort because of this topic,
17 maybe we could talk about how you handle that discomfort
18 and the anxiety that might be there in your world
19 because of that disconnect." But I can't -- and I don't
20 impose, you know, the parents' goals on that teenager.
21 Again, I can't force that teenager to change.
22 If the teenager wants to change, obviously he or she
23 can. There's lots of examples. People wouldn't come to
24 therapy if they didn't think they could change.
25 So, you know, there are some things that

1 are -- you know, that they want to talk about that
2 they'd like to change. "Great. We can do that. What
3 are they? We'll talk about what your goals are," and
4 we'll have a conversation about their goals and move in
5 that direction.
6 Q So am I understanding you correctly that in
7 the event a minor client's goals are different than the
8 parents' goals, it's the minor client's goals that you
9 will -- that you'll attempt to meet?
10 A The example I gave you was a teenager. I've
11 never met a five year old who says, "Dad, would you
12 please take me to the pediatrician so I can get my
13 immunization shots? I really like the way that hurts."
14 There's a place where parents do make
15 decisions for young minors. There's a place where
16 minors begin to be able to speak about things that are
17 important to them, and that's that handoff from parents
18 training children to stand on their own two feet. Where
19 does that occur on a time line? You cannot put a dot on
20 the time line and say "Here they are." But obviously
21 the older the minor is, the more they would have input
22 on those kinds of things.
23 So to your question -- I'm sorry. The
24 question was something about parents imposing -- or who
25 do I listen to?

1 Q Yes.
2 A Okay. I -- obviously parents setting a goal
3 for a five year old about learning to obey the first
4 time, I'm going to listen to the parent and not to the
5 five year old who says, you know, "But I don't want to
6 do it. I want to be in charge." But when it comes to a
7 teenager, who might have sexual orientation preferences
8 that are different than the parents, I can't force that
9 teenager to do anything.
10 If the teenager wants to talk about something,
11 that's all I can talk about is what they want to talk
12 about. I can't impose change because I can't change
13 that teenager that the parents may want. I can't impose
14 that on them because I can't change that teenager.
15 Now if that teenager wants to change, even in
16 sexual orientation issues or attractions or behaviors or
17 obedience behaviors or school behaviors or anything else
18 like that, then that teenager can experience change.
19 Q So I'm wondering if, given what you've said,
20 that if the minor client doesn't have something as a
21 goal, that you can't make the minor address it, why is
22 it then that parents are a part of setting the goals for
23 the therapy?
24 A Okay. Again, your question overlooks the
25 example I gave you of a six-year-old or a five-year-old

1 who doesn't want to obey. So I'm assuming your question
2 is talking about a 14, 15, 16 year old who has different
3 goals than parents, is that accurate?
4 Q I think that's fair enough.
5 A Okay. So assuming that that's what you're
6 talking about, why is it important to have everybody's
7 input on those goals?
8 They live under the same roof. These are
9 families that come to see me, and so if they have
10 different ways of handling whether or not somebody
11 should eat in their room and leave dirty plates on the
12 floor in their room, the teenager might have one
13 perspective on that and the parents might have another
14 perspective on that. They might disagree. And it would
15 be helpful, since they're all living under one roof, to
16 be able to talk about that, and maybe the teenager will
17 want to change that or maybe not. Maybe the teenager
18 doesn't want to talk about it but at least having a
19 conversation about "What are your goals? What are your
20 parents' goals? You know, we can -- we can understand
21 the starting point for where we're headed."
22 The question I ask people is: "Why are you
23 here? What brings you in today?" Because that gives me
24 an idea on why each person is there and how invested
25 they are in the process of change, what change they're

1 looking for individually. Is that common amongst each
2 of the family members? Who's most invested? Who's
3 least invested in that?
4 Q So let me use the example that you gave of a
5 minor who's got a messy room. What happens if the
6 parents say, "I would like for you to offer therapy to
7 my child, and my goal is to have ███ keep ███ room
8 clean," and then you meet with the minor client and the
9 minor client says, "That's not a goal of mine. I'm
10 perfectly comfortable with my messy room"? What happens
11 in that scenario?
12 A Okay. Off the top of my head, I can just
13 think of two routes that conversation might have.
14 They're certainly not the only two.
15 Part of that might be "So your parents want
16 you to have a clean room and they don't like the
17 standard of cleanliness that you've been keeping. Is
18 that causing -- is that conflict with your parents over
19 this topic causing you distress? If so, to what level?
20 What degree of distress? And is that something that you
21 would like to change? The distress piece. You know,
22 not the messy room, but the dissonance between you and
23 your parents. If that's something you'd like to change,
24 how invested are you in that change? What kind of
25 things would you be willing to do to bring about that

1 change?"
2 Second avenue of conversation might be with
3 the parents and, again, talking about the consequences.
4 So if your child is not, you know, making the bed and
5 folding the blanket at the end of the bed, that's
6 different than is your child -- you know, is there four
7 weeks' worth of laundry on the floor and bags of potato
8 chips and old ice cream bowls sitting on the floor?
9 "What consequences are you willing to put in place or
10 what conversations might you have or how can you work on
11 your relationship with your child so that they want to
12 do the things that you desire?" And we'll talk about
13 parenting, parenting issues then.
14 So depending whether it's the minor, whether
15 it's the parent, if they have different goals, those are
16 the two conversations that would be -- two of many
17 conversations that would come to the top of my head that
18 I would certainly pursue.
19 Q All right. Well, let's bring the conversation
20 closer to the matter at hand. How many clients have you
21 had where the issue to be addressed is the minor's
22 same-sex sexual attractions?
23 A I've dealt with four.
24 Q And what are their ages?
25 A 14, 14, 16, 16, to the best of my

1 recollection.
2 MR. MIHET: Object as to form on that
3 question, retroactively.
4 BY MR. ABBOTT:
5 Q And have each of those clients been clients of
6 yours since you've gone into private practice?
7 MR. MIHET: Form.
8 THE WITNESS: I've seen one of those clients
9 since then. Two of those clients I haven't --
10 their file is in my active files list, but I have
11 not interacted with them since I went into private
12 practice. And the fourth one, I don't believe I've
13 had any contact since private practice. I think
14 that one's a closed case.
15 BY MR. ABBOTT:
16 Q All right. So I'm clear, one client you had,
17 that carried over from your work at Spanish River and
18 you are still providing counseling for?
19 MR. MIHET: Form.
20 THE WITNESS: That's correct.
21 BY MR. ABBOTT:
22 Q Okay. Two of them you provided counseling for
23 at Spanish River and you expect that you might see them
24 or treat them in the future, but so far you haven't in
25 your private practice?

1 A When you say "treat them," the families are --
2 the families are clients of mine, not just the
3 individuals, so it's not just treating the child, okay.
4 I might see someone from the family. I might
5 see the child. I might see the parents and the child
6 together. That's an open file. It is a family file,
7 and it is an open file.
8 Q But you have not seen the minor since you
9 opened your private practice?
10 A That's correct.
11 Q And the last one is somebody that you provided
12 counseling for at Spanish River that you have no reason
13 to -- that's a closed case?
14 A At this point, yes.
15 Q In those four cases, doctor, have the goals of
16 the minor and the goals of the parents been materially
17 identical?
18 MR. MIHET: Form.
19 THE WITNESS: No.
20 BY MR. ABBOTT:
21 Q Okay. You have had one or more clients that
22 had different goals than their parents have had?
23 A That's correct.
24 Q And can you explain that to me? How many of
25 the clients and what has the conflict been?

1 A I had one client who -- whose parents came in
2 with the client because there were parental issues going
3 on of general parenting, had nothing to do with sexual
4 orientation, okay. And the parents also mentioned, "By
5 the way, our child is not heterosexual and is talking
6 about that, and we would like you to address that issue
7 as well, okay, and we would like your help on that
8 issue." I spoke with that minor child and there was not
9 an issue for the child, perfectly content with that.
10 The second one was -- let me back up. The
11 first one was not really interested in talking about the
12 issue, okay.
13 The second one was open to talking about the
14 issue, and I would describe that not necessarily that
15 the parents had different goals, but there was just a
16 season of curiosity and experimentation and opened to
17 talking about the issue.
18 The third client was experiencing discomfort
19 because of the way that ███ sexual orientation was
20 impacting ███ friendships, had different goals than ███
21 parents on that initially, and so we talked about the
22 discomfort that ██ was experiencing because that was the
23 point of agreement that we had. And the third client, I
24 would just categorize that as experimenting, and ██ was
25 certainly willing to talk and have a conversation.

1 Q All right. I hope you're going to remember
2 the order in which --
3 A I did. I wrote it down just so I'd have it.
4 Q Excellent. I think the first child, you told
5 me about the parents were concerned about the
6 orientation of their child --
7 A That's correct.
8 Q -- and the child didn't want to talk about it?
9 A Let me articulate that a little bit
10 differently. [redacted] was fine talking about it, but [redacted]
11 wasn't interested in talking about how that could change
12 for [redacted].
13 [redacted] was content with the way [redacted] was feeling,
14 the way [redacted] was behaving, and that was not causing [redacted]
15 distress in [redacted] life. It was causing [redacted] distress in
16 [redacted] conflict with [redacted] parents, but [redacted] was willing to
17 talk about any of that, just not about -- [redacted] didn't
18 want [redacted] parents to change [redacted] and [redacted] didn't want me to
19 try to change [redacted], and [redacted] came in with that concern and
20 [redacted] expressed it.
21 Q And so what did you do as a result of that?
22 Would the counseling sessions deal at least in part on
23 the subject of the sexual orientation of the child or
24 did it not?
25 A Other than just gathering information up front

1 the first week or two about -- and ███ would share about
2 ████ -- I guess the first week is kind of an overview
3 week, "Bring me up to speed on what's going on in your
4 life." ███ would -- ███ would bring it up every now and
5 then in the first many weeks we met. I didn't initiate
6 that. I didn't ask that. And, interestingly enough,
7 over the course of our sessions together ███ went from
8 identifying ███████ as a lesbian to identifying ███████
9 as a bisexual to saying "I'm heterosexual. I have a
10 boyfriend."
11 The idea of changing ███ sexual orientation
12 like that was never a part of the conversation that we
13 had in the office other than just to say that "So your
14 parents are -- you and your parents have a conflict over
15 your sexual orientation. How are you handling that
16 conflict? What's that like for you? How do you -- how
17 do you deal with that stress with your parents?"
18 Q Other than the sort of initial meeting, the
19 initial goal setting meetings, are the parents of your
20 minor clients kept apprised as to the progress of the
21 therapy?
22 A Yes. Absolutely.
23 Q In the case that we're talking about, was it
24 the sexual orientation of the child that caused the
25 parents to arrange for the therapy?

1 A That was one of two issues. The primary issue
2 was disobedience and conflict in terms of obeying mom.
3 Q As to the first issue, did the parents follow
4 up with you from time to time and ask you questions
5 like, "How are the sexual orientation issues with my
6 child going? What kind of progress are we making?"
7 MR. MIHET: Form, and mischaracterizes the
8 testimony.
9 THE WITNESS: I told them initially when I
10 first spoke with them that "I cannot change your
11 [redacted]," and so they knew from the outset that my
12 position was not going to be trying to change their
13 [redacted], okay.
14 They knew from the conversations that I had
15 with them after the first session that the time
16 together was really focusing on the obedience
17 issues and the explosive anger issues towards mom
18 and how to handle those, okay, and in working in
19 conjunction with a psychiatrist to help some
20 medication issues and maybe stabilize some of the
21 outbursts and some of the anxieties and depression
22 that might have been going on there.
23 So my conversations with mom were about those
24 things, not about the sexual orientation issues.
25 However, at times I recall mom might have said, you

1 know, "Oh, by the way, this is what [redacted] said this
2 week about sexual orientation, and did [redacted] mention
3 that to you in counseling? You know, did [redacted]
4 mention [redacted] has a boyfriend now or whatever? You
5 know, did [redacted] mention [redacted] bisexual now?" And mom
6 would give me a little comment like that every now
7 and then, but our --
8 My conversations with mom were never back and
9 forth, me or [redacted], addressing issues of how -- "So
10 how are you doing changing my [redacted]s sexual
11 orientation?" Again, because that was not a part
12 of the discussion with the [redacted] and that's not
13 something I can do anyways, but [redacted] demonstrated
14 that [redacted] could change if [redacted] wanted to on that
15 issue. So it's not that change is immutable
16 because I didn't change [redacted]. I had nothing to do
17 with that.
18 BY MR. ABBOTT:
19 Q So the child's mother didn't express any
20 disappointment to you that the subject of sexual
21 orientation was not a big part of the ongoing therapy
22 sessions?
23 A As I recall, [redacted] understood that there was a
24 lot to talk about and [redacted] understood that we would be
25 talking about the things that the [redacted] was most

1 comfortable talking about and wanted to talk about
2 because ███ understood that the ██████ would not come
3 back if we didn't talk about the things that the
4 ██████ wanted to talk about. And that if I tried to
5 force her to talk about other issues, that ███ wouldn't
6 come back. And even if the mother got ███ in the car
7 and brought ███ in my office, that ███ would sit there
8 and not say anything and waste ███ mom's money.
9 And ███ said -- ███ said ███ wouldn't walk
10 out, but ███ wanted to sit there the whole hour and
11 waste mom's money as punishment for mom, and so mom knew
12 the expectation, we'd go with what the ██████ wants to
13 talk about.
14 Q Right. So there wasn't disappointment
15 expressed to you or words to the effect of "Hey, doctor,
16 I brought my child in to you for two reasons and one of
17 the things doesn't seem to be being addressed"?
18 A Never.
19 Q Okay.
20 A Never. Uh-uh.
21 Q Okay. Your second client expressed some
22 curiosity and experimented in homosexual activity?
23 A Yes.
24 Q And that client was willing to talk to you
25 about that subject?

1 A To a -- to a very small degree.
2 Q Did that client express to you in the goal
3 setting meeting a goal to address sexual orientation or
4 sexual orientation attractions?
5 A No, but the client expressed -- ███ shared
6 something that had happened to ███ which caused ███
7 great distress and depression and anxiety. ███ was
8 dealing with an eating disorder and with cutting, and
9 that had all had its onset after this particular
10 incident.
11 And ███ was willing to talk about those things
12 in very limited degrees which is, in my experience,
13 common. When teenagers come in with issues like that,
14 the conversations start slowly because we're building
15 trust.
16 Q So at least at the goal setting session the
17 minor didn't say words to the effect "I would like my
18 orientation or my sexual attractions to decrease"?
19 A No. ███ was distressed by the experience that
20 ███ had had and confused by the feelings that came with
21 that experience that were contrary to ███ sincerely held
22 religious beliefs. And that conflict, that dissonance
23 there was very difficult for ███, and ███ didn't know
24 how to handle those confused feelings. And layering
25 upon that the way that manifested in eating issues and

1 in cutting issues and in suicidal thoughts that was --
2 it was a slow conversation, at ███ pace, on the topics
3 that ███ wanted to talk about.
4 Q Did ███ parent or parents express as a goal in
5 the initial goal setting meetings to address their
6 child's sexual orientation?
7 A No. That had -- that didn't come up until
8 down the road. When I say "that didn't come up," I mean
9 her thoughts and feelings of confusion were not
10 something that ███ articulated in that initial meeting.
11 That actually came out weeks later.
12 Q I understand. When -- and when it did come
13 out, did you advise ███ parent or parents about this
14 issue that had arisen?
15 A As I recall, they advised me, and then ███
16 shared it with me in a counseling session before I
17 brought it up.
18 Q Okay.
19 A So they gave me the background information,
20 said "Let ███ bring it up," and ███ did.
21 Q All right. And in that conversation did the
22 client's parent or parents express as a goal that the
23 child not have those sexual attractions?
24 A They realized that these sexual attractions
25 were causing great confusion for their ████████ because

1 they were contrary to ███ sincerely held religious
2 beliefs and that ███ didn't know how to handle that
3 delta, that difference. And they were disturbed by the
4 experience that ███ had that had triggered all of this
5 and asking for help dealing with the whole package of
6 all of those things.
7 They -- when the conversation went to ███
8 sexual feelings -- when the conversation shifted at some
9 point from "anxiety, depression because of what happened
10 to me" to "I had these confused sexual feelings," at
11 that point the parents did talk with me about how to
12 help ███ make sense of those, and their preference was
13 that those feelings would not be something that would
14 continue. And we talked about how, you know, it's
15 really up to your █████ about what ███ wants and that
16 █████ would direct -- you know, give us some direction to
17 go on how to handle that.
18 Q Was progress made? Did the client make peace
19 with the tension between his or her sincerely held
20 religious beliefs and the distressing incident?
21 A I can tell you that progress was made and the
22 communication with dad and mom increased, and that the
23 trust that ███ had in ███ parents increased to the point
24 that ███ was able to talk about things openly with ███
25 parents, and that ███ -- the shame -- the level of shame

1 ███ felt because ███ had been a victim of something,
2 that was hard for ███, but ███ realized that ███ was not
3 bad and that there was no reason for ███ to feel shame
4 for that, and ███ was able to talk about those feelings
5 and how they had affected ███.
6 In terms of change in ███ sexual feelings and
7 the confusion from that, I -- I don't recall that being
8 something that we discussed before I referred ███ on to
9 another counselor.
10 Q All right. I have just a few more questions
11 on that subject, and I promise I'll move on.
12 So may I assume that the troubling incident
13 involved the minor client and another individual of the
14 same gender as the client?
15 A That's correct. And it was unwanted.
16 Q Do you have a sense -- did the client express
17 to you any prevailing sexual orientation? Does that
18 subject come up? Did you ask --
19 A ███ had never had any -- I did ask about that
20 and ███ --
21 MR. MIHET: Let me object as to form.
22 THE WITNESS: Okay. And ███ had never had any
23 same-sex attractions, thoughts, activities before
24 that incident.
25 BY MR. ABBOTT:

1 Q Okay. And at the time that you referred ████
2 on, was ████ still having either same-sex attractions or
3 those confusing thoughts about the incident?
4 A Yes. That had heightened at that point.
5 Q And what did you do in the counseling sessions
6 to address those feelings that your client was having?
7 A The same-sex feelings? Because there are a
8 lot of feelings we're talking about here.
9 Q Yes, yes, thank you.
10 A We talked about how that was confusing for
11 her. "How do you make sense of feeling this way and yet
12 having this experience that was contrary to what you
13 wanted and what discomfort is that causing you now? How
14 does that dissonance reflect itself in your feelings and
15 thoughts, emotions, behaviors, and your level of
16 anxiety, depression, your suicidal thoughts, things that
17 are a trigger for your eating disorder?" So we talked
18 about it in that regard.
19 Q Did you talk with the client directly about
20 how he or she might go about decreasing those same-sex
21 attractions or feelings?
22 A No, I did not.
23 Q The third client I wrote down was having
24 trouble with friends or schoolmates with regard to
25 sexual orientation issues.

1 A That's correct.
2 Q And can you give me any more details on that?
3 A Individual had told his friends that ██ was
4 gay and had been in school with these other friends
5 since ██ was in kindergarten, and all of the sudden ██
6 was -- the relationships changed and ██ was feeling
7 distant and unincluded.
8 Q Do you remember -- or I suspect you do -- was
9 that client's goal to help to no longer be gay or was
10 that client's goal to get along better with ███
11 schoolmates and friends?
12 A Okay. To your comment, help to -- "help to no
13 longer be gay" I think is how you worded that?
14 Q Yeah. I think you told me that the client
15 announced to you that ██ had told ███ friends that ██
16 was gay.
17 A Right. So my response to you on that would be
18 labeling somebody is not -- like, that is not something
19 I found helpful in my practice. We're talking about
20 behaviors. We're talking about anxieties. We're
21 talking about distress. We're talking about depression,
22 those kinds of things, so I'm not looking to help ███ be
23 not gay, okay.
24 Q Fair enough. I'm sorry, you weren't finished.
25 Go ahead.

1 A My conversations with ███ were never about
2 that. We spoke about the discomfort ██ experienced in
3 the change in ███ relationships with ███ friends, why
4 that might be there, how to deal with that. And ██ was
5 also dealing with this conflicts with religious views
6 for ████ as well, and ██ was trying to make sense of that
7 issue in ███ life, so we talked about that.
8 Q And did you offer any advice for that client?
9 MR. MIHET: Form.
10 THE WITNESS: What do you mean by "advice"?
11 Clarify that for me.
12 BY MR. ABBOTT:
13 Q Well, once again, I've confessed to not having
14 a good background in terms of what you do but,
15 hypothetically, if this client had come in and told you
16 that story, a hypothetical person might have said, "Find
17 new friends," or a hypothetical response would be, "Stop
18 telling them that you're gay and maybe those people will
19 be more friendly to you."
20 So I'm just trying to understand if you -- if
21 you had any advice for how those conflicts might be
22 resolved by your client.
23 A Yeah, I understand what you're saying there.
24 I wasn't there to give ███ advice. We talked about pros
25 and cons for telling ███ friends that ████ gay.

1 Obviously when ■ shared that information,
2 that caused the change in their relationship. Was that
3 beneficial for ■ or was that change causing ■
4 distress? Was it -- were there benefits to letting ■
5 friends know that ■ was gay? And if so, what were
6 those benefits? And then ■ would have to weigh in the
7 balance the pros and the cons and make decisions about
8 how vocal ■ was because ■ was the same -- ■ was the
9 same buddy they played with all along, you know, and
10 they had a friendship that went back many years. And so
11 ■ would have to weigh in the balance the pros and cons
12 of what ■ said to these friends based upon what ■
13 thought the reactions would be and how that would
14 influence ■ relationship with them.
15 So we talked about that. It was not to give
16 ■ advice and telling ■ which way to go with that, I
17 was providing ■ an opportunity to talk through that
18 issue and speak about that with me in a safe context
19 where ■ would not be judged on that and ■ would be
20 able to make ■ own decision on what ■ thought would
21 be in ■ own best interests.
22 Q All right. What did the client decide? I
23 mean when the client weighed those pros and cons did --
24 were you told about any decision in terms of whether the
25 client would continue to tell ■ friends that ■ was

1 gay?
2 A That was -- that was a recuring theme. The
3 distress with ███ friends was a recuring theme that came
4 up week after week after week. And I think also we're
5 dealing with a minor who might not remember what
6 homework ███ has for math class, and so to remember, you
7 know, some of these things as ███ talking with ███
8 friends might not have been easy for ███ as well just
9 developmentally where ███ was.
10 As far as I know, to this day ███ still says
11 ███ gay and is content with that in ███ own mind and
12 sees a discord between that and ███ faith, and ███
13 still trying to sort that out.
14 I believe there was a season, as I recall
15 right, there was a season when he didn't talk as much
16 with ███ friends about these things because ███ felt like
17 they didn't understand how to handle that issue. And
18 they were just, you know, young guys and to ███ it was
19 more important to be included in things like "Let's go
20 to a movie on Friday night" than to talk about ███ gay
21 thoughts and feelings and have some kind of a negative
22 consequence in terms of not being invited to a movie
23 night with ███ buddies.
24 Q Is this individual still a client of yours?
25 A This is -- this is a client that I would still

1 say the family's file is in my active list, but I have
2 not interacted with this family I would say more than
3 once since the beginning of 2018. And it was not with
4 [redacted] when I interacted with the family. It was not about
5 [redacted] and it was not with [redacted].
6 Q Has your involvement with this client changed
7 in any way that you attribute to a Boca Raton ordinance
8 or a Palm Beach County ordinance?
9 MR. MIHET: Objection. Form, asked and
10 answered.
11 THE WITNESS: I have not spoken with this
12 client since the Palm Beach County -- with this
13 minor, since the Palm Beach County or the City of
14 Boca ordinances were passed.
15 If this client were to come see me now, I do
16 not feel that I would be able to have the
17 conversations with [redacted] now under these ordinances
18 that I would have been able to have back then.
19 BY MR. ABBOTT:
20 Q And what do you intend to do as a response?
21 MR. MIHET: Form.
22 THE WITNESS: I don't understand your
23 question.
24 BY MR. ABBOTT:
25 Q What if the child makes an appointment to come

1 see you -- well, you don't have a secretarial staff.
2 Are the appointments made by contacting you directly?
3 A Yes. They would contact me directly.
4 Q So if you were contacted to schedule an
5 appointment, will you agree to schedule the appointment?
6 A Yes, I will.
7 Q And you will have an hour long session,
8 assuming that's what the client wants?
9 A Yes, I will.
10 Q And what will happen differently in that
11 session in light of the ordinances?
12 MR. MIHET: Form.
13 THE WITNESS: If the client brings up these
14 issues, I would -- I would inform the client and
15 the parents that "Right now the ordinances from the
16 city and the county prevent me from having these
17 conversations about your sexual feelings to the
18 degree that they're unwanted. If you want those
19 sexual feelings to change so your discomfort goes
20 down with your friends, you know, I'm not able to
21 have that conversation. I don't have anything" --
22 I mean it's a hypothetical. I'm not really
23 sure how to answer that other than the way that I
24 did.
25 BY MR. ABBOTT:

1 Q Okay. But your thought is you would have the
2 session, you would just have to -- would you tell your
3 client that certain things cannot be discussed in the
4 session?
5 A This was one of many topics that I spoke with
6 this client about, so if this client called me to
7 schedule a session, I would not assume that that session
8 would involve sexual orientation issues, and so I would
9 have that session just as if we were -- somebody else --
10 they were coming in any other time about obeying
11 parents, just to use that example again. And if the
12 sexual orientation issue came up, I would -- I would
13 have to say that "Because of the current ordinances, I
14 cannot talk about that topic, but I can talk about any
15 of these others that you have in mind."
16 Q You wouldn't discuss that topic in general?
17 And by the topic -- forgive me. Just so I'm clear, the
18 topic is I think the minor announcing to his friends
19 that he's gay and then being troubled by the reactions
20 his friends have?
21 MR. MIHET: Form, asked and answered.
22 THE WITNESS: Well, I'm not an attorney. As I
23 read the ordinance, the city and the county
24 ordinances, I believe that I'm not able to discuss
25 unwanted sexual feelings, just to choose one of

1 those off the list.
2 If ██ starts talking about this and ██ says,
3 "By the way, I really don't like these feelings,
4 they've affected my life in a negative way" and I
5 continue that conversation, then I would find
6 myself liable to the dog catcher to come and give
7 me a fine in the form of the code enforcement
8 officer. And so I would not want to place myself
9 in a position where I could be financially,
10 legally, or criminally liable for having a
11 conversation, speech with a minor, about something
12 ██ wanted to talk about so at this point my
13 attorneys have advised me to not have that
14 conversation.
15 And my client -- if I can just keep going
16 here --
17 BY MR. ABBOTT:
18 Q Sure.
19 A My client and I would both be in that case
20 restricted from what we would be able to say. I see
21 that as a violation of the First Amendment. That would
22 be a violation of my religious preferences to be able to
23 speak.
24 Most of my clients are Christians. This
25 family, this ████ a Christian. ██ self-reports as a

1 Christian, and ██ has expressed that that is in
2 dissonance with this issue in ███ life, and so that's --
3 again, that's a First Amendment, Freedom of Religion and
4 Freedom of Speech issue. I would see those to be
5 problems.
6 MR. MIHET: Mr. Otto, I'm sure it was
7 unintentional, but let me remind you not to
8 disclose any conversations that you and your
9 attorneys have had --
10 THE WITNESS: Yes.
11 MR. MIHET: -- within the confines of this
12 lawsuit.
13 THE WITNESS: Thank you.
14 BY MR. ABBOTT:
15 Q Has that client, in your previous sessions,
16 expressed to you that ███ was troubled by being gay? He
17 or she, forgive me.
18 A ██ was troubled by the reaction that ███
19 friends had. And, by the way, that had a negative
20 impact on ████ personal life and ████ relationships.
21 Q Do you know or do you have a belief one way or
22 the other in terms of whether or not that client
23 actually has or had same-sex attractions?
24 A Yes. ██ told me that he did.
25 Q But ██ didn't tell you that ██ wanted those

1 attractions to go away, ██ told you ██ was troubled by
2 ████ friends' reactions to the announcement that ██ was
3 gay?
4 A That's correct.
5 Q So I hate to go backwards, the first client
6 that we talked about, the -- I believe the ████ who
7 was -- who expressed to you that ███ was not distressed
8 by ███ same-sex attractions --
9 A Yes.
10 Q -- is ███ still a client of yours?
11 A I would say that file is in the closed box.
12 Not to say ████ wouldn't come back in the future to see
13 me, but that one's closed out right now.
14 Q All right. If that minor were to call to
15 schedule a session with you, would you agree to schedule
16 the session?
17 A Yes.
18 Q And is there anything that has gone on in past
19 sessions that you think could no longer be discussed
20 with the patient in light of the county and city
21 ordinances?
22 A Yes.
23 Q And what matters are those?
24 A As ███ talked about changing from lesbian to
25 bisexual to heterosexual -- again, those conversations

1 ███ initiated that. I never brought that up. I didn't
2 ask ███ those questions. ███ just volunteered the
3 information. We talked about that some; ███ feelings
4 about that, ███ feelings about what that journey was
5 like for ███, and about making sense of ███ sincerely
6 held religious beliefs and ███ feelings and ███
7 behaviors.
8 And as I read the ordinances -- again, I'm not
9 an attorney, but as I read the ordinances, those
10 conversations would cross the line and be unallowed
11 right now under the current ordinances.
12 Q That client never expressed distress about ███
13 sexuality?
14 A No. ███ was very content with being fluid.
15 Q And yet you would not have similar sessions
16 with her in the future because of the ordinances?
17 A I'm not an attorney, but as I read the
18 ordinances, there is a preferential view of moving from
19 heterosexual to something else, but a provision -- but a
20 prohibition of against moving in the other direction.
21 And because ███ chose to move in the other direction
22 toward heterosexuality, I would feel that I would be on
23 very shaky legal ground.
24 And again, I'm not an attorney, but I would
25 feel like I'd be on very shaky legal ground to have that

1 conversation because that is not the preferred view as I
2 read the ordinances from the county and the city.
3 Q And the second client that we talked about
4 earlier, the one who had expressed curiosity and had
5 experimented and talked to you to a small degree, is
6 that person still a client of yours?
7 A No. I referred her to another professional.
8 The family is still a client of mine for other issues.
9 Q Your relationship with the -- with the minor's
10 parents hasn't been affected in any way by either of the
11 ordinances, has it?
12 A I would disagree with that statement.
13 Q Tell me how your relationship for the
14 counseling that you have provided to the parents have
15 been altered by the ordinances.
16 A The parents were experiencing and continue to
17 experience distress because of the incident that
18 happened to their [redacted] as well as because of the
19 nature of that same-sex incident and the way that that
20 has affected their [redacted], with [redacted] confusion and
21 feelings and "How do I make sense of these sexual
22 feelings up against what I've always thought and felt
23 and believed if my sincerely held religious beliefs are
24 a part of that?"
25 And so the parents were very interested in

1 talking with me about how to handle that as parents and
2 to be wise in that journey and what they could be
3 sensitive to and how they could help [redacted]. And I believe
4 that those conversations would be crossing the line
5 legally, according to the way I read those ordinances
6 from the city and county. I wouldn't be comfortable
7 having those now.
8 Q Do you think that the ordinance would restrict
9 your discussions with the parents who indicated to you
10 that they are troubled by that incident involving their
11 [redacted]?
12 A Well, remember that my client is the family
13 and this [redacted] is a part of the family. [redacted]
14 receiving individual counseling from another counselor
15 at this point, but [redacted] still a part of the family, and
16 so at times all family members might come in and be in
17 my office.
18 So even though [redacted] not my individual client
19 right now, [redacted] might be coming in and be a part of the
20 family discussion. And so because [redacted]s still a part of
21 that family unit that is my client, I would feel
22 uncomfortable having those conversations because I feel
23 that I would be liable under the ordinances.
24 Q Have you, in fact, had an individual session
25 with either of the minor's parents since the ordinances

1 were adopted?
2 A Yes, I have.
3 Q And was that session constrained in any way by
4 the ordinances?
5 A No. We were talking about the suicidal issues
6 and eating disorder and cutting.
7 Q If the parents in a future session expressed
8 to you concern about their child's sexual orientation or
9 sexual attractions, would you feel prohibited from
10 engaging in those conversations?
11 A I'm sorry, my mind wandered. Can you say the
12 question again?
13 Q Of course. If those parents schedule a future
14 session with you, and if in that session they express to
15 you concern about their child's sexual orientation,
16 would your treatment be affected in any way by the
17 ordinances?
18 MR. MIHET: Form.
19 THE WITNESS: I would tell them that I don't
20 feel comfortable talking about that because of the
21 ordinances, and I would not talk about that.
22 BY MR. ABBOTT:
23 Q By the way, the referral of the minor to
24 another mental health care professional, was that
25 motivated in any way by the ordinances?

1 A No, it was not.
2 Q And long last that brings us to the fourth
3 client --
4 A Before we do that --
5 Q Yes, sir.
6 A -- I've been drinking this water bottle. Can
7 we take a break?
8 Q Of course.
9 A It's been an hour.
10 Q Of course.
11 A Thank you.
12 (Thereupon, a short break was taken from 12:02
13 p.m. to 12:08 p.m.)
14 BY MR. ABBOTT:
15 Q Doctor, before we took a break I was going to
16 ask you about the fourth minor client that we discussed,
17 and I believe you told me earlier that that client had
18 engaged in some experimenting with, I guess, same-sex
19 attractions and was willing to talk about it?
20 A That wasn't -- well, define "experimenting."
21 What do you mean by that?
22 Q Well, I don't think we need to go down that
23 rabbit hole. That's just the word that I wrote down.
24 A Okay.
25 Q Do you remember the fourth client to whom you

1 referred?
2 A Yes, I do.
3 Q And would you tell me about that client?
4 A Yes. That client came in because the parents
5 brought ███ in dealing with same-sex attractions,
6 same-sex --
7 The reason I ask experimenting, it was
8 experimenting with pornography, it wasn't experimenting
9 with people, okay. And so that was the extent of ███
10 experience. And that was causing distress in their
11 lives and as a family and distress for ███, and he was
12 unsure how to make sense of all of that.
13 Q Okay. Did you have an initial meeting with
14 both the parents and the minor to establish goals for
15 the therapy?
16 A Yes. I don't recall whether that was the two
17 of them in the room together or whether that was mom
18 first and ███ second or ███ first and mom second, but I
19 did receive input from both of them on goals.
20 Q All right. And I think you made it clear that
21 the mother's goal at least was to either decrease the
22 child's same-sex attractions or get ███ to stop looking
23 at what I presume to be homosexual pornography?
24 A Yes, I think that's an accurate statement.
25 Q And how about the minor client, what were ███

1 goals?
2 A ■ was -- ■ was concerned about the conflict
3 with mom and wanting to see that decrease. ■ was -- ■
4 was trying to figure out how to make sense of what ■
5 was seeing and the feelings that ■ was having as a
6 result of that, the sexual feelings ■ was having as a
7 result of that given that that was different than what
8 ■ had been taught and what ■ believed was true based
9 upon ■ faith.
10 And again, I worked at a Christian counseling
11 center. My clients are -- to a vast majority, would
12 identify themselves as Bible believing Christians. Not
13 just parents coming in and beating their kids over the
14 head with that, but this is what the kids would tell me.
15 This is what this ■ would tell me. And so ■ was
16 trying to make sense of that disconnect in ■ life or
17 that dissonance.
18 Q All right. Would it be fair to say then that
19 the minor expressed two goals to you? One was ■ wanted
20 to address the conflict ■ was having at home with ■
21 mom or with ■ parents?
22 A Uh-huh.
23 Q Yes?
24 A Yes. That's correct.
25 Q But --

1 A And that conflict was not just about this
2 issue. That was a broad conflict so...
3 Q Okay. But the minor also expressed, as a goal
4 or as a concern, the feelings ██ was having and how that
5 compared to ███ religious teachings?
6 A ███ wanted to figure out how to make sense of
7 all of that and how to remove the disconnect between
8 those two.
9 Q And this particular client, when did you first
10 start treating ███?
11 A I can just say it would have been in the last
12 two years. I don't have a date for you.
13 Q And is this one of the clients that has
14 transitioned from Spanish River to your private
15 practice?
16 A Yes.
17 Q Do you remember about when your last session
18 was with this minor client?
19 A I believe I met with ███ once since I started
20 the private practice.
21 Q And I know that hasn't been a long time, but
22 can you estimate for me about --
23 A Within the last two months. One time within
24 the last two months.
25 Q And has your treatment been to address the

1 same goals that were identified by ▇ and ▇ mom at the
2 outset?
3 MR. MIHET: Form.
4 THE WITNESS: The issue that ▇ came in most
5 recently for was twofold: To share with me some
6 changes in ▇ life where ▇ felt like ▇ had
7 matured and grown, and ▇ wanted to share that
8 because that was germane to some of the things that
9 we had been talking about in the past. And ▇ was
10 excited to do that, so ▇ asked ▇ mom to come in
11 and talk with me.
12 And the second issue was talking about going
13 into the next school year and what that was going
14 to look like for ▇. So the same-sex issue was
15 not a part of what we talked about. It was not on
16 the table.
17 BY MR. ABBOTT:
18 Q Okay. So the maturity that ▇ had gained was
19 not directly related to any sexuality?
20 A ▇ was talking about things and ways that ▇
21 had grown as a person. Some of that included ▇ faith,
22 and ▇ had shared some experiences that ▇ had had in
23 that regard, and ▇ felt that ▇ had some -- been able
24 to connect some things in his own mind about ▇.
25 And the issue of sexuality was not a part of that.

1 Although growing in ███ faith certainly does
2 impact the sexuality topic because the discord that ██
3 was experiencing, that we talked about in the past, had
4 to do with ███ faith and the dissonance between that and
5 ████ sexuality. Does that make sense?
6 Q Sure.
7 A Okay.
8 Q But just so I'm clear, the subject of the
9 client's sexuality or sexual preferences didn't come up
10 in this recent session?
11 A That's correct.
12 Q May I assume then, sir, that the city
13 ordinance or the county ordinance didn't affect that
14 session?
15 MR. MIHET: Form, mischaracterizes his
16 testimony.
17 THE WITNESS: I -- to the extent that we
18 didn't talk about that specifically, the ordinances
19 did not affect this session; however, we did talk
20 about ███ sincerely held religious faith which was
21 connected to the conversations of sexuality in the
22 past. And ███ incidence of looking at homosexual
23 pornography had decreased. Looking at pornography
24 in general had decreased, and ██ was glad for those
25 changes. And they had reduced the conflict with

1 ███ mom, and ███ mom was glad for those changes.
2 BY MR. ABBOTT:
3 Q And those topics were discussed during this
4 last session?
5 A Yes, sir.
6 Q And the existence of the ordinance didn't
7 constrain you -- didn't constrain that session in any
8 way?
9 MR. MIHET: Form.
10 THE WITNESS: Again, my sessions are -- what
11 we talk about in my sessions is client-focused and
12 client-driven.
13 In this particular session, I don't think that
14 there was anything -- in fact, there was nothing
15 that I felt would have crossed the line with those
16 ordinances; however, ██ could have brought up other
17 topics that we have talked about in the past that
18 would have been, "Whoa, whoa, I can't talk about
19 that now." And so you're asking me in a way that
20 makes it sound to me like I'm saying that the
21 ordinance, therefore, did not affect my
22 relationship with this client, and I do not agree
23 with that statement.
24 BY MR. ABBOTT:
25 Q The ordinances have not affected any session

1 with that client, would you agree with me?
2 A The ordinances --
3 MR. MIHET: Go ahead.
4 THE WITNESS: The ordinances affect my ability
5 to talk about topics with this client that I have
6 spoken with ███ about in the past. To be clear,
7 before the ordinances were passed.
8 I could not have those same conversations
9 today with this client because of the ordinances,
10 even if the client brought them up, which ██ did in
11 the past.
12 BY MR. ABBOTT:
13 Q I think we're going round and round on this,
14 but let me ask one more time: Did you not say anything
15 at this session with your client that you would have
16 been otherwise inclined to say if the ordinances did not
17 exist?
18 MR. MIHET: We are going round and round. I
19 am going to object to form, asked and answered, but
20 go ahead.
21 THE WITNESS: I didn't say anything in this
22 session that I would feel would cross the lines of
23 the ordinances, and my client did not bring up
24 anything in this session that would have crossed
25 the lines in the ordinances. ███ has brought up

1 topics in the past that if ■ brought up today, I
2 would not be able to talk about.
3 BY MR. ABBOTT:
4 Q Well, you win, you got -- I got tired of that
5 before you did.
6 Doctor, do you hold -- I think I asked you
7 this earlier but I just want to be clear, do you hold
8 professional counseling licenses in any state other than
9 the state of Florida?
10 A No, sir.
11 Q And you have not, in fact, counseled in any
12 state other than the state of Florida?
13 A I've never had a counseling session with
14 anybody. There's informal conversations that I've had.
15 I've spoken at marriage conferences around the country
16 on military bases, but you don't need a license to talk
17 with somebody about their marriage.
18 To have a formal counseling session and to
19 charge them, you know, that's different. I have not
20 done that outside of the state of Florida.
21 Q Well, I suspect you don't know about the
22 licensing requirements in other states, but maybe you do
23 about Florida. What is it that one can do if they have
24 a marriage counseling license like you have in Florida
25 and what can't one do?

1 MR. MIHET: Form.
2 THE WITNESS: What can't one do? I can't
3 practice any other profession.
4 What can one do? I can hang my shingle and
5 advertise and perform services as a marriage and
6 family therapist.
7 BY MR. ABBOTT:
8 Q So you can advertise your services?
9 A That's correct. And I've advertised my
10 services and would like to continue to, and the
11 ordinance prevents me from doing that.
12 Q And you can hold yourself out to the world to
13 be a therapist?
14 A That's correct.
15 Q What else is it, if you can describe, that one
16 without a license cannot do in your field in this state?
17 A That's really a question for an attorney. I
18 don't know. I believe there's certain titles that are
19 restricted that people cannot use unless they have a
20 license.
21 They can't say they're a licensed marriage and
22 family therapist unless they actually are. I'm not sure
23 what the punishment is, but I would imagine that there
24 are restrictions on people who do not have the license
25 that I have.

1 Q Okay. Could you describe for me in some way
2 when you're acting as a therapist, perhaps outside of
3 the office, and when you're not? For instance, you
4 mentioned earlier you spoke at a marriage conference in
5 another state. You apparently felt comfortable doing
6 that.
7 MR. MIHET: Form.
8 THE WITNESS: You say when I'm acting as a
9 therapist. Again, I would make a distinction
10 between the speech that I conduct with clients and
11 actions or conduct. With that caveat, I have --
12 I'm sorry, I forgot the question.
13 BY MR. ABBOTT:
14 Q Yeah. Here's what I'm trying to get at: If I
15 were in the adjoining seat in a plane near you and we
16 struck up a conversation and we started to talk about my
17 life, is there a point that you would be concerned that
18 the things you say might be practicing your profession
19 or might be a session in the eyes of the law?
20 A I see sessions -- and again, I'm not an
21 attorney, but I would see sessions as something where I
22 have a consent form signed, I have a payment agreement
23 signed, I'm in my office, or in a -- I see clients
24 outside of my office also, but there are consent forms
25 signed and payment agreements signed and we work on

1 goals together, and there is a formal relationship that
2 is understood by me and by my client who has employed
3 me.
4 Barring that kind of a formal relationship,
5 casual conversations certainly -- you know, I'm willing
6 to share at points, you know, to help people, but that's
7 different than a formal counseling relationship that I
8 have established with a client who has come to see me
9 for purposes of helping them walk through things that
10 give them distress.
11 Q Okay. There is some paperwork involved to
12 establish the relationship?
13 A Yes. We've talked about some of those
14 earlier, the forms and things.
15 Q All right. Doctor, when did you first learn
16 about the city of Boca Raton ordinance?
17 A Approximately two weeks after it was passed,
18 unfortunately.
19 Q And I don't -- are you aware that the
20 ordinance was considered and voted upon at two
21 governmental meetings?
22 A In the city of Boca or in Palm Beach County?
23 Q In the city of Boca.
24 A No. I am only aware of one.
25 Q Okay. But your understanding is that you

1 learned about the ordinance about two weeks after it was
2 passed?
3 A That's correct.
4 Q Does that seem as if it's probably late
5 October of 2017?
6 A What was the date that it was passed? I
7 thought it was -- was it late October or was it late
8 November or -- I don't recall the date it was passed.
9 Q Okay. I believe it was passed on October 10th
10 of 2017, if that helps.
11 A Yeah. I found out -- approximately two weeks
12 after that, I believe, is when I found out about it.
13 Q All right. How did you find out about it?
14 A I believe I received an email from a colleague
15 or a phone call from a colleague.
16 Q And who is that colleague?
17 A I have no idea.
18 Q And what was the substance of the conversation
19 that you and the colleague had?
20 A It wasn't --
21 MR. MIHET: Form.
22 THE WITNESS: I believe it was an email
23 because I don't recall it being a dialogue back and
24 forth. I think it was just an email saying that
25 "This is what was passed. Here's what the

1 ordinance says. Boca passed it, you know, two
2 weeks ago, and Palm Beach County is considering
3 passing the same thing. Here's the date for the
4 Palm Beach County Commissioner's hearing on it."
5 BY MR. ABBOTT:
6 Q Did you read the essence of the email to
7 encourage you to oppose the county ordinance?
8 A I recall that part of the email was
9 informative saying, you know, "This is what current
10 ordinances are governing or attempting to govern our
11 profession, so make sure you operate within the
12 boundaries of the ordinances and the laws that are
13 established."
14 And part of it was saying that, "How did this
15 happen? We didn't know about it beforehand. We would
16 have liked to go speak and share as professionals who
17 deal with this issue with the city council, who does not
18 have the same degrees that I have and does not
19 understand the issues that my clients bring to the table
20 and the desires of my clients to talk about these
21 things, to apply their Freedom of Speech in my office,
22 to apply their Freedom of Religion in my office. And
23 the city council passed this and we never had a
24 chance -- I never had a chance because I didn't know to
25 say something to them about this side of the issue that

1 they might not have heard about. So let's go make sure
2 that the county hears about this side of the issue."
3 Q Did you do anything in response to that email?
4 A I shared it with as many colleagues as I could
5 find. I shared it with pastors. Not necessarily that
6 email, but the information. I shared it with pastors.
7 I shared it with headmasters from schools. I shared it
8 with other counseling professionals, medical doctors,
9 friends from Boca Raton and Palm Beach County that I
10 know from various places.
11 Q And did you encourage those people to do
12 anything?
13 A Absolutely.
14 Q What did you encourage them to do?
15 A "Go and let your voice be heard on how you
16 feel about this issue at the county commission meeting."
17 Q Did you offer any advice or encouragement with
18 regard to what to do about the city ordinance?
19 A I don't recall doing that because I'm not an
20 attorney and I wouldn't know how to handle that.
21 As we were talking about the county ordinance,
22 we were put in touch with -- or contacted Liberty
23 Counsel and --
24 Q I don't mean to cut you off, doctor, but if
25 we're getting close to talking about attorney

1 communications --
2 A No. I'm saying I don't know -- I don't recall
3 knowing how to handle the city ordinance, so I contacted
4 my attorney.
5 Q Have you had any contact with the City of Boca
6 Raton or its elected officials that pertains to the
7 ordinance in any way?
8 A Scott Singer, the acting mayor, he was the
9 city council member at the time. He knocked on my door
10 campaigning for mayor a couple weeks ago.
11 Q A couple of weeks ago?
12 A The election was yesterday, and he was
13 campaigning in the last few weeks, knocking on doors in
14 other neighborhoods, and he came to my neighborhood as
15 well.
16 Q And did you have a conversation with now Mayor
17 Singer about the ordinance?
18 A I told him I wasn't going to vote for him
19 because he voted for this ordinance.
20 Q Have you had any other communication with ██e
21 City of Boca Raton that pertains in any way to the
22 ordinance?
23 A No, sir.
24 Q What did you do in connection with learning
25 that the -- that Palm Beach County was considering the

1 ordinance that they ultimately adopted?
2 A I shared with you that I passed that
3 information on to many people --
4 Q Yes, sir.
5 A -- that I listed. I came to the first hearing
6 on that, and I spoke at the first hearing.
7 Q Did you do anything else in connection with
8 the county ordinance?
9 A I emailed with county commissioners between
10 the two hearings.
11 Q I gather you didn't attend the second hearing
12 on the ordinance?
13 A No. I was a witness in federal court that day
14 for a guardianship case, so my wife took my notes and
15 used her two minutes to share my thoughts.
16 Q I should have asked you this earlier. I think
17 you told me that you were on a list to be -- to be
18 appointed in connection with guardianship issues?
19 A That's correct.
20 Q Is that a list for state courts or federal
21 courts or both?
22 A It's a list for the 15th Circuit Court. The
23 reason I was in federal court that day was because the
24 individual that I had interviewed was -- had federal
25 charges against him, and the guardianship may or may not

1 have been germane to how that would be disposed of. But
2 the guardianship was a 15th Circuit Court case.
3 Q Doctor, are sexual preferences or same-sex
4 attractions, are they genetically caused?
5 MR. MIHET: Form.
6 THE WITNESS: I think that the research shows
7 that there's nature and nurture in the sense of --
8 let me back up. Strike that.
9 The research shows that there are many
10 influences that will -- many factors that will
11 influence people's sexual orientation. I have not
12 seen any research to show that there is a gay gene
13 or that people are born that way.
14 I have seen research that deals with a lot of
15 environmental factors, relationship factors, abuse
16 factors, lots of things like that. But I guess
17 that answers your question.
18 BY MR. ABBOTT:
19 Q You may have, but let me ask you another
20 question. And you may tell me that you just answered
21 this question, but do you believe sexual preference or
22 sexual orientation is a choice?
23 MR. MIHET: Form.
24 THE WITNESS: We're talking about behaviors.
25 Behaviors are choices. If we're talking about

1 attitudes, I can change my attitude about things.
2 You can change your attitude about things.
3 In my experience, and as I read the
4 literature, there is the ability for clients to
5 change on this particular issue of sexual
6 orientation. Do all people? No. Do some people?
7 Yes. And, again, that's why my practice is
8 client-driven and not Dr. Otto driven with my
9 preferences and my personal views, but it's my
10 client's goals, not my goals. And so -- I don't
11 know. I think that answers your question.
12 BY MR. ABBOTT:
13 Q On those occasions when you got a client that
14 tells you that they're gay or that they have same-sex
15 attractions, do you assume that to be the case or do you
16 somehow try to evaluate whether, in fact, the client is
17 gay or does have those attractions?
18 A If they tell me, do I assume that they're
19 speaking the truth to me?
20 Q Yes, sir.
21 A Yes. I believe my clients.
22 Q Okay.
23 A Now if you're talking about if my clients tell
24 me they are gay, I don't see that as an immutable,
25 unchangeable dynamic because in my practice we're

1 talking about behaviors and attitudes and things like
2 that, which do change, which can change if people choose
3 to change them, and if they sometimes choose to get help
4 to change them.
5 So if you're saying if my client comes to me
6 and says "I am this way," it's said in concrete, no, I
7 don't see that concept as set in concrete. Behaviors
8 and attitudes do change and can change if clients want
9 them to.
10 Q Do you have clients who are gay or who have
11 same-sex attractions and have announced to you that
12 those attractions are not unwanted?
13 MR. MIHET: Form, asked and answered.
14 THE WITNESS: I've told you about the four
15 minor clients.
16 BY MR. ABBOTT:
17 Q Yes, sir.
18 A You have the answers on those.
19 I've had a small handful, maybe on one hand I
20 could count them, of clients who are gay who came to see
21 me who are content with that, and I had probably two or
22 three, but that was not the issue that they came in for
23 and so we didn't talk about it.
24 Q Have you ever found that the root problem
25 that's causing distress that has caused a client to come

1 to see you is that client's sexual orientation even
2 though the client didn't announce to you at the
3 beginning of the sessions that that was the problem?
4 MR. MIHET: Form.
5 THE WITNESS: I think I've given you details
6 of four clients that I've addressed that with, the
7 four minor clients I've addressed that with, and I
8 have not addressed it with any adult clients. If
9 you have specifics about any of those four that I
10 did not already answer, I can do that, but I don't
11 know that I have anything else to add to what I've
12 already shared.
13 BY MR. ABBOTT:
14 Q No, that's fair. You have answered my
15 questions completely as to those four clients, so I
16 guess my question pertains to adult clients. Have you
17 ever determined or with your help has a client ever
18 determined that the root cause of their discomfort is
19 their sexual orientation when they didn't initially
20 believe that to be the case?
21 MR. MIHET: Form.
22 THE WITNESS: Two thoughts on that. This case
23 is about an ordinance addressing minors and my
24 dealing with minors, that's one.
25 Number two, I have dealt with, just as I said

1 a minute ago, just a very small number of
2 homosexual adult clients who came in for other
3 reasons. I don't remember off the top of my head
4 what those other reasons might be, but they would
5 be things like PTSD, we talked about that earlier,
6 or things like relationship issues with a parent
7 and how to handle that, or sibling issues or
8 something like that. So I don't have any other
9 information other than that.
10 MR. ABBOTT: All right. Is this a good time
11 to break? It's about how much time you said.
12 MR. MIHET: If you're close to being done --
13 MR. ABBOTT: I am not.
14 MR. MIHET: You're not close? Okay, then
15 let's break.
16 MR. ABBOTT: Okay.
17 (Thereupon, a lunch break was taken from 12:38
18 p.m. to 1:44 p.m.)
19 BY MR. ABBOTT:
20 Q Doctor, the way I read your Complaint, it
21 alleges, at least in part, that the City of Boca Raton
22 ordinance infringes the free speech rights of your minor
23 clients.
24 First of all, I'll ask you have I read that
25 correctly? Is that one of your allegations?

1 A Yes.
2 Q And can you explain to me, doctor, how the
3 Boca Raton ordinance affects your minor client's speech
4 rights?
5 MR. MIHET: Objection. Calls for a legal
6 conclusion.
7 THE WITNESS: If my clients come in and they
8 want to talk about their same-sex attractions and
9 they want help reducing or eliminating attractions
10 or behaviors or -- and I am not able to help them,
11 then that's restricting the topics that we can talk
12 about in the office back and forth, and that would
13 be taking place in the form of a conversation,
14 which takes two people; and if one of us is not
15 allowed to speak about that because I'm a licensed
16 person under the control of the ordinance, then
17 that conversation is stifled.
18 BY MR. ABBOTT:
19 Q So let me break that down. Is it your
20 understanding of the city ordinance, doctor, that a
21 client of yours would not be allowed to tell you, in a
22 counseling session, that he is experiencing unwanted
23 sexual attractions?
24 A Well, you'd have to fight that out as
25 attorneys, and I'm not an attorney, but as I read the

1 ordinance --
2 MR. MIHET: Same objection, by the way. Thank
3 you.
4 THE WITNESS: -- the ordinance does prevent me
5 from having conversations, which take two people to
6 have a conversation, two or more, and it prevents
7 me from participating in a conversation that my
8 clients wish to participate in and I -- I see that
9 as impacting my client's ability to have a
10 conversation they want to have.
11 BY MR. ABBOTT:
12 Q So if I understand you correctly, you read the
13 ordinance as prohibiting you from having a conversation
14 with your minor clients on the subject of same-sex
15 attractions?
16 MR. MIHET: Same objection, also form, also
17 mischaracterizes the testimony.
18 THE WITNESS: Not having a conversation on
19 same-sex attractions but on their unwanted -- if
20 they have -- if this particular hypothetical client
21 has unwanted same-sex attractions, then the
22 ordinance would prevent me from doing that.
23 And Freedom of Speech is -- it secures our
24 freedom of thought and our freedom of ideas, that
25 was Justice Kennedy in the NIFLA case. And if my

1 clients cannot speak and I cannot speak, then the
2 city or the county are squashing my client's and my
3 ability to exercise their First Amendment rights.
4 MR. MIHET: Are you sure you're not a lawyer?
5 I'm just kidding.
6 THE WITNESS: I'm just a lay person reading
7 the ordinance and reading the Constitution and
8 reading the --
9 MR. MIHET: That was a joke, for the record.
10 BY MR. ABBOTT:
11 Q Doctor, have you -- have you been prosecuted
12 under the city ordinance?
13 A No, sir.
14 Q Have you been threatened with prosecution
15 under the city ordinance?
16 A No, sir.
17 Q Has anyone from the city approached you and
18 suggested in any way that you are violating the
19 ordinance?
20 A No, sir.
21 MR. MIHET: Form.
22 BY MR. ABBOTT:
23 Q Do you advertise your professional services?
24 A I have, yes.
25 Q And how do you do that?

1 A I had a website that I was on at the Spanish
2 River Counseling Center. I've advertised on the radio.
3 The counseling center handled a lot of
4 advertising, and so it went a lot of other places that I
5 was not privy too. I think the Good News Newspaper was
6 one, but it was print, electronic, radio, flyers that
7 would be promoting the counseling center, promoting my
8 services at different places around the county.
9 Q The website that you refer to, that was a
10 website maintained by Spanish River?
11 A Yes, sir. That's correct.
12 Q The advertising on the radio, was that done by
13 Spanish River or have you done that in your private
14 practice?
15 A Some of that was by Spanish River, some of
16 that was when I was invited to speak on the radio. And
17 so it wasn't private practice, it wasn't the counseling
18 center, it was me as a professional speaking on a topic
19 on the radio, and that was pretty good advertising.
20 Q You have not purchased an advertising spot on
21 a radio station --
22 A No, sir.
23 Q -- since you opened your business?
24 A No, sir.
25 Q The Good News Newspaper, was that work done by

1 Spanish River or in your -- for your business?
2 A That was Spanish River for the counseling
3 center specific. There are many counselors that work at
4 the counseling center, so I benefited from the generic
5 advertising that Spanish River Counseling Center did.
6 And I believe that there was some in the Good
7 News Newspaper. I can't -- you know, I mean I'm -- I'm
8 about 90 percent sure that there was print advertising
9 there over the course of many years.
10 Q I promise I am not going to get too far into
11 your personal business, but I'm just curious: When you
12 worked at Spanish River, were you salaried or were you
13 compensated by your clients or some combination of the
14 two?
15 A I was not salaried. Clients would pay for the
16 sessions, and a portion of that would be my split and a
17 portion would be the counseling center's split.
18 Q You would give a percentage to the counseling
19 center?
20 A That's correct.
21 Q The flyers to which you referred, were those
22 done by Spanish River or by your company?
23 A There was some done by Spanish River. There
24 was some done by me individually. Since I opened my new
25 practice I have not made any flyers yet, but I will.

1 Q So is it fair to say that in your -- since you
2 have started your own private practice, you have not
3 advertised at all?
4 A That's correct.
5 Q Do you intend to?
6 A Absolutely.
7 Q Has anything prevented you from advertising to
8 date?
9 A Yes.
10 Q What has that been?
11 A I was out of town for approximately two weeks
12 with a family emergency, right in the middle of that.
13 Q Do you read the city ordinance as restricting
14 your advertising in any way?
15 A Yes, I do.
16 Q How so?
17 A Well, I'm not an attorney --
18 MR. MIHET: Objection. Calls for a legal
19 conclusion.
20 THE WITNESS: -- I would say that my read of
21 it is that it prevents me from advertising to say
22 "If your child has unwanted same-sex attractions,
23 that I would be glad to help your minor child with
24 those issues."
25 BY MR. ABBOTT:

1 Q Doctor, we talked a little bit earlier in the
2 deposition about the informed consent that you obtain
3 from your minor clients and the parents of your minor
4 clients?
5 A Yes.
6 Q You, through your attorney, you have provided
7 me an informed consent form that's titled "Counseling
8 Regarding Unwanted Same-Sex Attractions and Behaviors."
9 Are you familiar with that form?
10 A Could you show it to me for just a second?
11 Q I didn't bring it with me. You can just tell
12 me you're not sure if --
13 A Generally speaking, yes, I am aware that I
14 have such a form. That might not be the exact title
15 but --
16 MS. PHAN: I have it. Do you want it?
17 MR. ABBOTT: That's all right.
18 MS. PHAN: Okay.
19 THE WITNESS: -- I do have a form like that,
20 yes.
21 BY MR. ABBOTT:
22 Q Okay. And is that form, is that the extent of
23 the informed consent? Do you present it to your
24 prospective clients and have them sign it?
25 A Yes.

1 Q And do you have --
2 A Dealing with the same-sex issues.
3 Q Of course. Of course. And do you have
4 discussions with your clients about the contents of that
5 form?
6 A All of the forms that I use in my office we
7 discuss in general terms. If they have specific
8 questions about it, then we'll answer those questions
9 before they sign the forms.
10 Q Do you recall having any particular
11 discussions with your minor clients or their parents
12 with regard to the informed consent for unwanted
13 same-sex counseling?
14 MR. MIHET: Form.
15 THE WITNESS: No, I've never had any
16 objections, any issues with that.
17 I'm sorry. What was your question? I just
18 want to make sure.
19 BY MR. ABBOTT:
20 Q Well, I might have missaid it because there
21 was an objection. What I meant to ask is: Have you had
22 any conversations with your clients about that form?
23 A No, sir.
24 MR. MIHET: Form.
25 BY MR. ABBOTT:

1 Q I've seen you write this as an answer to an
2 interrogatory that you sent to the county, and the
3 question was: What would you do if a minor client
4 wanted counseling so that they can be more comfortable
5 about their same-sex attractions? And you told them
6 words to the effect that you would refer that client to
7 professionals who would be better able to help -- to
8 help them.
9 A Yes, sir.
10 MR. MIHET: Let me object because I don't
11 think that's the full extent of his response. I
12 think it's maybe mischaracterizing it.
13 MR. ABBOTT: Okay.
14 BY MR. ABBOTT:
15 Q Is what I said a fair summary of what you
16 would do under those circumstances?
17 MR. MIHET: Form.
18 THE WITNESS: As part of what I would do, I
19 would refer that to a therapist who focuses on that
20 particular issue in the same way that I would refer
21 somebody with an eating disorder to somebody who
22 focuses on that particular issue.
23 We, as professionals, all have our little
24 slice of the pie that we function within most
25 frequently, and we refer other cases consistently

1 back and forth to other professionals who can
2 provide the best level of care for those issues
3 that the clients bring to the table.
4 BY MR. ABBOTT:
5 Q In your profession, sir, are there ethical
6 restrictions against abandoning a client?
7 MR. MIHET: Form.
8 THE WITNESS: Yes. Yes.
9 BY MR. ABBOTT:
10 Q The scenario that we just discussed whereby a
11 therapist refers a patient to another mental health care
12 professional, is that abandonment to your understanding
13 of that prohibition?
14 A No. It's important to make a good handoff as
15 best as I can on my end, so I would provide a few names
16 of professionals who might be able to help on that
17 particular issue, whatever the issue would be, more
18 effectively than I could, and I would make sure that
19 they have name and contact information on those
20 professionals, and I would follow-up to make sure that
21 they had at least reached out.
22 Q Okay. Doctor, are you familiar with a
23 treatment method called behavioral techniques?
24 A No, sir.
25 Q No?

1 A No, sir.
2 Q Are you familiar with cognitive behavioral
3 techniques?
4 A I'm aware of the titles of these. They're
5 not -- I do client-focused therapy and I focus on my
6 clients' issues and what they bring in. I have
7 colleagues who do that, that I know, but it's not my
8 expertise.
9 Q Okay. Fair enough. So you don't engage in
10 behavioral techniques or cognitive behavioral
11 techniques?
12 A No, sir. I would say I'm under the category
13 of client-focused therapy.
14 Q Okay. Do you employ psychoanalytic
15 techniques?
16 A No, sir.
17 Q For your minor clients who have unwanted
18 same-sex attractions, do you ever recommend surgical
19 treatment?
20 MR. MIHET: Form.
21 THE WITNESS: No, I do not.
22 BY MR. ABBOTT:
23 Q Do you recommend substance-based methods,
24 medications or the like?
25 MR. MIHET: Form.

1 THE WITNESS: When my clients are dealing with
2 depression, anxiety, I work hand-in-hand with
3 psychiatrists and medical doctors. If they do not
4 have one that they've been seeing, then I recommend
5 a couple. And they might help with depression
6 medications or anxiety medications or mood
7 stabilizers.
8 If you're talking specifically about the
9 medications or sex hormones or cross-sex hormones,
10 my understanding of the research that was just
11 published even this last month says that cross-sex
12 hormones have an increase in heart issues and
13 strokes, and I would not think that that would be
14 in the benefit of my clients so I would not
15 encourage them to pursue that. And I'd show them
16 that research and let them read it for themselves,
17 but that's a significant increase, according to
18 that study, on heart issues, heart attacks, and on
19 strokes.
20 BY MR. ABBOTT:
21 Q Have you ever recommended to a minor client
22 seeking counseling with regard to same-sex attractions
23 that they take any drugs, any substance?
24 MR. MIHET: Form.
25 THE WITNESS: Not for that issue. If they're

1 having problems sleeping, I've recommended at times
2 that sometimes it can be helpful to take something
3 to help them sleep because we heal when we sleep.
4 And if they're dealing with depression and not
5 sleeping, then that might be something that I would
6 recommend.
7 BY MR. ABBOTT:
8 Q Okay.
9 A Again, in conjunction with a medical doctor or
10 psychiatrist.
11 Q Of course. But you have never recommended
12 sexual stimulants or depressants?
13 A No, sir.
14 Q Or hormone treatment?
15 A No, sir. No, sir.
16 Q Okay. Are your minor clients who have
17 same-sex attractions, do you ever treat them in group
18 therapy?
19 A No, sir.
20 Q Do you engage in hypnosis?
21 A No, sir.
22 Q Do you apply aversion therapy?
23 A No, sir.
24 Q Are you familiar with a concept called
25 "bioenergetic"?

1 A No, sir.
2 Q As far as you know, you don't practice it?
3 A No, sir.
4 Q Okay. Do you practice psychoanalysis?
5 A No, sir.
6 MR. MIHET: Asked and answered.
7 BY MR. ABBOTT:
8 Q Doctor, are you a member of any professional
9 organizations?
10 A I was in the past a member of the American
11 Association of Marriage and Family Therapists, but I
12 currently am not.
13 Q That's the only professional organization that
14 you have been a member of?
15 A That's correct. American Association of
16 Christian Counselors I might have been. I can't
17 remember. I don't recall, but I'm not now.
18 Q Do you have any affiliation with the American
19 Psychiatric Association?
20 A Nothing other than reading some of their
21 journal articles.
22 Q Any association with the American
23 Psychological Association?
24 A No, sir.
25 Q Any association or affiliation with the

1 American Counseling Association?
2 A No, sir.
3 Q Any involvement or association with the
4 National Association of Social Workers in the U.S.A?
5 A No.
6 Q Any relationship with the Royal College of
7 Psychiatrists?
8 A No.
9 Q Any affiliation or dealings with the Family
10 Research Council?
11 A What do you mean by affiliations or dealings
12 with?
13 Q Well, why don't you tell me. Have you had any
14 involvement with people associated with that
15 organization?
16 MR. MIHET: Form.
17 THE WITNESS: About 20 years ago I gave money
18 to them. I recently met someone who works there
19 and had about a ten minute conversation with her
20 about her son who is in the military like I was.
21 Other than that, no, sir.
22 BY MR. ABBOTT:
23 Q Do you have any dealings or affiliations with
24 the American Family Association?
25 A No, sir.

1 Q Do you have any dealings or affiliation with
2 the National Association for Research & Therapy of
3 Homosexuality?
4 A No, sir.
5 Q Have you read the City of Boca Raton ordinance
6 that has brought us here today?
7 A Yes, sir, I have.
8 Q Do you remember, sir, that the WHEREAS clauses
9 of the ordinance cite a number of papers and studies on
10 the subject of sexual orientation change efforts?
11 MR. MIHET: Objection. Form, and
12 mischaracterizes the document.
13 THE WITNESS: I've read it. I can look at it
14 and you can -- I can take a look and acknowledge
15 whether it does or it doesn't, but I don't recall
16 off the top of my head --
17 BY MR. ABBOTT:
18 Q Okay.
19 A -- if that's in the WHEREAS clause or not.
20 Q Sure. It's not a memory test and I'd be happy
21 to show it to you, but the question I was going to ask
22 you is: Are you familiar with the literature that's
23 cited in there? And is the answer going to be "maybe
24 yes and maybe no"?
25 A That's correct. Maybe yes and maybe no.

1 Q Okay. I guess you can mark this as Exhibit 1.
2 It's a copy of the city ordinance.
3 Doctor, can you take a look at what's now been
4 marked as Defendants' Exhibit 1, and can we agree that
5 that's the City of Boca Raton ordinance that's the
6 subject of this lawsuit?
7 A It sure looks like it, yes.
8 (Thereupon, Defendants' Exhibit 1 was marked
9 for identification.)
10 BY MR. ABBOTT:
11 Q Okay. I'm going to just ask you, and we're
12 going to go through these and you'll see that there are
13 references to a series of writings that I'm going to ask
14 if you're familiar with those writings.
15 So I'm on the last WHEREAS clause on page 1.
16 There's a reference to the American Academy of
17 Pediatrics in a 1993 article. Are you familiar with
18 that article?
19 A I've read a lot of the literature on this
20 topic. I've gone through and read as much as -- I'm
21 guessing that I've read that article, yes, but if you
22 have a copy of it and want to let me refresh myself with
23 it and read it here and look at it, I will, but I don't
24 remember it off the top of my head.
25 Q All right.

1 A But I know that I've prepared for this by
2 reading articles.
3 Q Okay. So maybe we can shortcut this. The
4 question I was going to ask you for articles that you're
5 familiar with is whether or not you agree or disagree
6 that these recitations are a fair recap of those
7 publications. Are you going to have opinions on that
8 subject?
9 MR. MIHET: Objection. Form. I think the
10 articles speak for themselves, and I think this
11 would be administering a memory test to the
12 witness, but go ahead.
13 THE WITNESS: I do believe that some of the
14 articles that I've read, that would include some of
15 the ones in here in the WHEREAS clauses, are
16 characterized in an oversimplified way because
17 there are portions of them -- and again, I'm just
18 speaking in generalities. I can't point to a
19 specific article unless you give me one, but, you
20 know, there are places where it says in one
21 paragraph that there is little research to show
22 that there is harm to minor clients who deal with
23 same-sex, you know, change and then working through
24 change and their attractions, and yet the way it's
25 cited is not in that direction. It will cite a

1 different portion of the article.
2 So I don't think that these WHEREAS clauses
3 that are three-and-a-half lines each can accurately
4 summarize a 95-page article. It's cherrypicking
5 one phrase or one concept out of it when that is
6 not what the article says in its entirety.
7 BY MR. ABBOTT:
8 Q Fair enough. Doctor, do you ever speak in
9 public with regard to sexual orientation change efforts?
10 A The only speaking I've done in public with
11 regard to sexual orientation change efforts is -- again,
12 I'm not saying I changed somebody's sexuality. I'm just
13 using that as a heading, a topic, for why we're here
14 today.
15 Q Okay.
16 A The only time I've spoken in public about that
17 would be at the county commission hearings, the one that
18 I went to. I've spoken in public about it with
19 individual people. I mean, it's in public. It's not in
20 my office, it's not in my house, it's out in public, but
21 it would be with an individual person. Like you asked
22 me earlier, what did I do when I found out that the city
23 ordinance had passed and the county was coming up, I
24 would consider talking with the school headmaster or the
25 pastor and sharing that information. That would be

1 speaking in public about this issue.
2 If you're asking if I've ever taught a class
3 on this issue or had a lecture or a seminar on this
4 issue, the answer would be no.
5 Q Do you intend in the future, sir, to speak on
6 the subject of sexual orientation change efforts?
7 MR. MIHET: Form.
8 THE WITNESS: I might, sure.
9 BY MR. ABBOTT:
10 Q Would you feel constrained in any way by the
11 city ordinance from speaking in public about sexual
12 orientation change efforts?
13 MR. MIHET: Form.
14 THE WITNESS: If that's considered
15 advertising. If I can't have flyers and pamphlets
16 and business cards out because that would be
17 considered advertising, then I might get in trouble
18 and I might be concerned about getting in trouble
19 with the ordinance in that way.
20 I would have to have a specific example and
21 not just a general hypothetical to give you a more
22 specific answer.
23 BY MR. ABBOTT:
24 Q All right. What I'm trying to gather is do
25 you feel constrained? Do you feel as if speech that you

1 wanted to give in public about sexual orientation change
2 efforts are thwarted by the city ordinance?
3 MR. MIHET: Form.
4 THE WITNESS: To the extent that it would be
5 construed as advertising, I would think that that
6 would be an issue with the city ordinance.
7 I don't necessarily know that the ordinance --
8 again, I'm not an attorney. You're asking for a
9 legal conclusion maybe, but I don't know if the
10 ordinance is telling me that I can't have a
11 conversation with somebody outside of my office on
12 this in a -- in a casual way.
13 BY MR. ABBOTT:
14 Q Have you, sir, in the past ever expressed your
15 views with regard to same-sex attractions to your
16 patients?
17 MR. MIHET: Form.
18 THE WITNESS: I'm just thinking through the
19 different kinds of clients that have come through
20 my office, not just these four that you're talking
21 about. With these four here specifically, the
22 answer -- I'm sorry. The four minors that we spoke
23 about earlier today, the answer would be, no, I
24 never spoke about my preferences with them.
25 With the adult clients who came in for other

1 issues that were homosexuals, no, I never spoke
2 about my preferences with them.
3 With regard to other clients who might come in
4 and say, "How do I deal with this with an adult
5 family member and an adult friend?" I don't
6 recall. I may or may not have in the course of
7 saying, "Hey, I'm a Christian, you're a Christian,
8 this is what our Bible says, how do you deal with
9 that? With kindness, with compassion, with love,
10 with -- you know, not shaming somebody."
11 You know, those are things that would be --
12 would that let a client know what my preference,
13 what my personal opinion is? Well, they already
14 know because we're Christians. I'm a Christian and
15 this particular client might be a Christian and,
16 therefore, we have a common set of values that we
17 come from sincerely held religion beliefs, so I
18 would imagine they would know what I'm saying and
19 they would know my opinion from what I'm saying,
20 but that's not hidden because that's why they're
21 there to see me.
22 BY MR. ABBOTT:
23 Q Are you concerned, doctor, that the city
24 ordinance constrains you in any way from expressing your
25 views to your clients?

1 MR. MIHET: Form.
2 THE WITNESS: Well, if you're asking me if it
3 does or not, that's a legal question. If you're
4 asking my opinion, I'm saying that I cannot speak
5 with clients, minor clients, about their unwanted
6 sexual feelings. I am prohibited by the city and
7 the county ordinance, in my understanding, from
8 doing that, and that's an infringement upon my
9 First Amendment, Freedom of Speech, and my ability
10 to speak about my sincerely held religious beliefs.
11 And so, yes, I would say that that is something
12 that the ordinance is restricting me from doing.
13 BY MR. ABBOTT:
14 Q Have you, sir, ever recommended sexual
15 orientation change efforts to any of your clients?
16 MR. MIHET: Form.
17 THE WITNESS: May I add to my previous answer?
18 BY MR. ABBOTT:
19 Q Of course. Of course.
20 A Okay. The damages for not being able to speak
21 could be --
22 MR. MIHET: He hasn't asked you anything about
23 damages. Let him ask a question about that.
24 THE WITNESS: All right. Next question.
25 BY MR. ABBOTT:

1 Q Yes, sir. I was asking if you have ever
2 recommended sexual orientation change efforts to any of
3 your clients.
4 A No, sir. And, again, that -- I have that
5 qualification of I don't see that as something that I
6 could do or anyone else could do --
7 Q Okay.
8 A -- but clients can change.
9 Q Have you ever referred a minor client to
10 receive unlicensed counseling, like to a member of the
11 church or a religious leader?
12 MR. MIHET: Form.
13 THE WITNESS: For this issue of sexual
14 attraction or in general?
15 BY MR. ABBOTT:
16 Q How about in general?
17 A Okay. In general, my clients come in --
18 again, my minor clients might be involved in their
19 church youth group and I know that there's value in
20 their mentors there, and so I encourage those
21 relationships, but I don't refer them to those
22 relationships for counseling. I have never -- never
23 done that.
24 Q Are you concerned, doctor, that the city
25 ordinance prohibits you in any way from referring your

1 minor clients to religious leaders?
2 MR. MIHET: Form, calls for a legal
3 conclusion.
4 THE WITNESS: I know religious leaders who are
5 licensed counselors. They would be prohibited from
6 having conversations in the same way I would be, so
7 I would not be able to refer them there and that
8 would be limiting.
9 BY MR. ABBOTT:
10 Q How about the religious leaders that do not
11 have licenses such as yours?
12 A My reading of the -- again, it's a legal
13 conclusion, but my reading of the document, the
14 ordinance says that it does not apply to anyone who's
15 not licensed.
16 Q So you wouldn't hesitate to refer a minor
17 client to a religious leader --
18 MR. MIHET: Form, misstates prior testimony.
19 BY MR. ABBOTT:
20 Q -- in Boca Raton?
21 A I would feel comfortable bringing all those
22 assets in this client's life to bear, and certainly
23 religious leaders would be among those assets that I
24 would like to bring in.
25 Q Okay. Doctor, I've taken up enough of your

1 time. I'm going to let the attorney to my left ask you
2 some questions.
3 CROSS-EXAMINATION
4 BY MS. PHAN:
5 Q Doctor, my name is Kim Phan and I represent
6 the county. So when I refer -- just for clarification
7 purposes, when I refer to "ordinance," I'm talking about
8 the county's ordinance because I know you've been
9 talking about the city's ordinance.
10 So I'd like to mark the first document as
11 county's exhibit --
12 THE COURT REPORTER: Do you want to go 1, 2,
13 3?
14 MR. MIHET: Can't we just do 2 so it will make
15 continuous sense?
16 MS. PHAN: Okay.
17 MR. MIHET: So Otto deposition Exhibit 2.
18 MS. PHAN: Okay. So here you go.
19 (Thereupon, Defendants' Exhibit 2 was marked
20 for identification.)
21 BY MS. PHAN:
22 Q So this is a document that I pulled off of the
23 Florida Health Department website, and I just wanted to
24 confirm the information on here. So this is -- this
25 says -- this document says Robert William Otto. Is that

1 you?
2 A Yes, it is.
3 Q And license number is MT2707. Is that you?
4 A That's correct.
5 Q Your license number?
6 A Yes.
7 Q And it says profession is licensed marriage
8 and family therapist; is that correct?
9 A Yes.
10 Q And that your license status is clear and
11 active, correct?
12 A Yes.
13 Q And your license expiration date is 3/31/2019,
14 correct?
15 A Yes.
16 Q And the license original issue date is
17 July 26, 2012?
18 A Yes.
19 Q And the address of record is 2400 West Yamato
20 Road, Boca Raton, Florida 33431; is that correct?
21 A No.
22 MR. MIHET: Let me object as to form. Are we
23 asking him to confirm what's written on here or
24 whether that's actually the case today?
25 BY MS. PHAN:

1 Q Is that the correct information for him -- is
2 that the correct current information for you?
3 A Okay. This is the address for Spanish River
4 Counseling Center, and I gave you the address of 4400
5 North Yamato Road, Suite 210 earlier today, so this will
6 need to be updated with the state. And again, I've been
7 out of town and I've been unable to stay on top of all
8 of that, but this is in the process of transitioning, so
9 that will be updated soon.
10 Q Gotcha. Okay. So you said you graduated from
11 Nova with your Ph.D around 2010, correct?
12 A Yes.
13 Q So how come your license original issue date
14 is July 2012? I'm just wondering about that gap.
15 A I was a registered intern before then, and I
16 know there was a couple years of gathering up all the
17 hundreds of hours that we needed -- that I needed for
18 licensure, so that must have been when I finished the
19 number of hours that was needed under the registered
20 intern license, and that's when it went from the
21 registered intern license over to the fully licensed.
22 Q And you obtained those hours working at the
23 Spanish River Counseling Center --
24 A Yes. That's correct.
25 Q -- is that correct?

1 A Yes.
2 Q Okay. So I'm going to hand you another
3 document. I'd like to mark this as Defendants' Exhibit
4 Number 3.
5 So Defendants' Exhibit Number 3 is a document
6 that I pulled off of Sunbiz.org. It's from the Division
7 of Corporations in the State of Florida. And same thing
8 here, I just want to verify that the information on this
9 document is correct and current, okay.
10 So it says here that this is for a Florida
11 limited liability company, SDG Counseling, LLC. Is that
12 your business that you were speaking of earlier about
13 opening around July?
14 A Yes, it is.
15 (Thereupon, Defendants' Exhibit 3 was marked
16 for identification.)
17 BY MS. PHAN:
18 Q Okay. So it says here the date filed is
19 July 5, 2018. Is that when you filed with the state?
20 A I would -- it sounds about right, yeah.
21 Q Okay.
22 A That might have been when the paperwork was
23 processed at the state. I might have sent it in at the
24 end of June but, yeah, that looks right.
25 Q And that address, that's the correct address,

1 the 4400 North Federal Highway, Suite 210?
2 A Yes. That's correct.
3 Q Okay. And the mailing address, 233 NE 31st
4 Street, Boca Raton, that's correct?
5 A That's my residence. Yes, that's correct.
6 Q Okay. And it lists here that you're the
7 manager, correct?
8 A That's correct.
9 Q Okay. And it lists Shannon Otto as also a
10 manager; is that correct?
11 A That's correct.
12 Q And what is your relationship with Shannon
13 Otto?
14 A She's my bride of 25 years.
15 Q Congratulations. That's all I have for that
16 document. The next document I'd like to mark is
17 Defendants' Exhibit Number 4.
18 So this is a document that is titled "Robert
19 W. Otto, Ph.D," and it has the Bates number Otto 001.
20 This is something that we received through discovery
21 responses from your attorney. Is it safe to call this
22 your resume?
23 A Yes.
24 (Thereupon, Defendants' Exhibit 4 was marked
25 for identification.)

1 BY MS. PHAN:
2 Q Okay. And is the information on this resume
3 true and accurate?
4 A To the best of my knowledge, yes.
5 Q And did you prepare this resume?
6 A Yes, I did.
7 Q And when did you prepare this resume?
8 A That would have been sometime after the suit
9 was filed. I don't recall what month that would have
10 been.
11 Q And why did you prepare this resume?
12 A Because I believe that was a part of the
13 interrogatories that you sent to me, and this was in
14 response to one of the questions, as I recall.
15 Q Okay. So has it been revised since -- or when
16 was the last time it was revised?
17 A In preparation of the interrogatories.
18 Q Okay. That's all I have for this document.
19 The next document I have is -- or I'd like to
20 mark Defendants' Exhibit Number 5. So this document is
21 titled "SDG Counseling, LLC." And it states it's
22 "Informed Consent For Counseling Regarding Unwanted
23 Same-Sex Attractions And Behaviors." It's Bates number
24 OTTO -- I'm sorry, not OTTO. Otto 008 through Otto 009.
25 This is also another document that we received

1 from your attorney in response to our discovery request.
2 Is the information on here true and accurate of the
3 informed consent that you give to your clients regarding
4 unwanted same-sex attraction and behaviors?
5 MR. MIHET: Form.
6 THE WITNESS: Yes. This is a form that I use
7 for clients with unwanted same-sex attractions.
8 (Thereupon, Defendants' Exhibit 5 was marked
9 for identification.)
10 BY MS. PHAN:
11 Q And when was this document created?
12 A As part of my opening up my LLC and going on
13 my own private practice.
14 Q So would you say around July 2018?
15 A Yes. And July 5th is when that LLC started,
16 and slightly before or slightly after that we've been
17 updating the forms, and this was a part of that process.
18 Q Okay. So when was the last time this form or
19 the most recent time this form was updated or revised?
20 MR. MIHET: Form.
21 THE WITNESS: In the last couple of weeks,
22 last month. I can't give you a date. Again, I've
23 been out of town for a good portion of that so...
24 BY MS. PHAN:
25 Q Okay. That's all I have for this document for

1 now. One more question about this document, the
2 informed consent. Is this a document that you created?
3 A This is -- yeah, this is a document that I
4 created that I -- as part of going on my own, revising
5 forms and updating forms, I had to create things for my
6 new company, so yes.
7 Q Okay. So the next document I'd like to enter
8 is Defendants' Exhibit Number 6, and it's titled "SDG
9 Counseling, LLC, Payment Agreement"?
10 A The first page that's on the top, yes.
11 (Thereupon, Defendants' Exhibit 6 was marked
12 for identification.)
13 BY MS. PHAN:
14 Q And the Bates number is Otto 002?
15 A There's Otto 003, Otto 004, 5 and 6 and 7 also
16 to this.
17 Q Okay. So we'll go through all of them. So
18 Otto 002 through Otto 007, could you take a minute to
19 review that?
20 A Sure. I just did.
21 Q Okay. You just did?
22 A Uh-huh.
23 Q Okay. Now did you create these forms?
24 A Yes, I did.
25 Q Okay. And is the information on it true and

1 accurate?
2 A Yes.
3 Q And is the information on it current?
4 A Yes.
5 Q And when did you create these documents?
6 A Again, it was a part of the July, beginning of
7 August, end of June kind of process of creating forms
8 and transitioning to the private practice, so somewhere
9 in there.
10 Q Okay. That's all I have for that document.
11 Since you've been in private practice, have
12 you engaged in therapy sessions or counseling sessions
13 in any other location other than your office with minor
14 clients regarding unwanted same-sex attractions?
15 MR. MIHET: Form, compound, vague and
16 ambiguous.
17 THE WITNESS: Since I went on my own?
18 BY MS. PHAN:
19 Q Since you went into private practice with SDG
20 Counseling.
21 A Okay. So you're asking me did I violate the
22 ordinances? Did I conduct any counseling with minors
23 with SOCE issues since July when the ordinances went
24 into effect? You're asking me if I violated the
25 ordinances by conducting counseling? Did I violate -- I

1 mean that seems like you're trying to trap me.
2 MS. PHAN: Can you repeat the question for
3 him, Dr. Otto?
4 THE COURT REPORTER: Sure. "Since you've been
5 in private practice, have you engaged in therapy
6 sessions or counseling sessions in any other
7 location other than your office with minor clients
8 regarding unwanted same-sex attractions?"
9 MR. MIHET: Same objections, also asked and
10 answered.
11 THE WITNESS: Okay. The answer is, no, I
12 haven't conducted any counseling sessions with
13 minors on same-sex attraction issues since the
14 ordinances were passed, which would include the
15 time since I opened my private practice.
16 BY MS. PHAN:
17 Q Okay. Now while you were at Spanish River
18 Counseling, prior to the ordinance being passed, what
19 other locations have you practiced other than at your
20 office location in Boca Raton?
21 A Okay.
22 MR. MIHET: Form.
23 THE WITNESS: I have seen clients in
24 unincorporated Boca Raton way out west, outside the
25 city limits. I've also seen clients in Delray.

1 And both of those are regular scheduled
2 appointments, ongoing.
3 BY MS. PHAN:
4 Q Are those the only two or three locations that
5 you've seen clients while you were at Spanish River
6 Counseling --
7 MR. MIHET: Form.
8 BY MS. PHAN:
9 Q -- Center within the last 12 months?
10 MR. MIHET: Form.
11 THE WITNESS: No. I met a ███ on a basketball
12 court once, and I met somebody else at Panera Bread
13 once. I went to the Outback Steakhouse with a dad
14 and ███ once. I also met at a gym.
15 MS. PHAN: I'd like to know --
16 MR. MIHET: I'm sorry, could you let him
17 finish his answer?
18 THE WITNESS: And also at the gym. So you're
19 asking what city that would be in?
20 BY MS. PHAN:
21 Q Exactly.
22 A All right. So Boca Raton and Delray Beach,
23 Florida.
24 Q Okay. Do you have a business card with SDG
25 Counseling?

1 A Yes, I do.
2 Q Is that something you have on hand that we can
3 make a copy of?
4 A Yes, it is.
5 Q I'll make a copy --
6 MR. MIHET: I'm sorry, let me see it first.
7 THE WITNESS: One for everybody.
8 MS. PHAN: Oh, I can have one? Okay.
9 THE WITNESS: There's no room for the sticker
10 on it, sorry.
11 MR. MIHET: We'll go ahead and accede to your
12 request. Generally we prefer document requests to
13 be made in writing in advance of the deposition,
14 but we'll make an exception for this one.
15 BY MS. PHAN:
16 Q How many clients does SDG currently have?
17 A What do you mean by how many clients do I
18 currently have? How many am I seeing a week or how many
19 active clients do I have?
20 Q How many active clients do you currently have?
21 MR. MIHET: Form.
22 THE WITNESS: I'm going to guess about 50, 60,
23 somewhere in there.
24 BY MS. PHAN:
25 Q Do you currently have any minor clients that

1 you are practicing or engaging in conversion therapy as
2 defined by the ordinance right now at SDG Counseling?
3 MR. MIHET: Objection. Form, asked and
4 answered at least four different times today, but
5 go ahead one more time.
6 THE WITNESS: No.
7 BY MS. PHAN:
8 Q Can you just describe some of the services
9 that SDG offers?
10 A It's all talk therapy. It's all counseling,
11 speech.
12 Q And in what subject matters though?
13 A I've had clients come in -- again, this is a
14 representative list, certainly not exhaustive. I've had
15 clients come in dealing with depression, anxiety,
16 parenting issues, marriage issues, affairs dealing with
17 divorce, dealing with sexual issues, dealing with
18 pornography, post-traumatic stress. That's probably a
19 good bulk of what I do.
20 Q Do you currently only work at SDG Counseling
21 or do you work at another -- do you have another
22 employer?
23 MR. MIHET: Objection. Asked and answered.
24 Counsel, I'm going to give you a little leeway
25 here, but we're not going to sit down for

1 essentially the same questions that were already
2 asked by the city.
3 He's already gone, exhaustively, through his
4 employment, whom he works for, and he's listed
5 every employer that he's currently had. I've asked
6 that you move on to an area that has not yet been
7 covered rather than trace back the same questions.
8 Go ahead, please.
9 THE WITNESS: When you say currently employed
10 and currently working in, I'm employed by SDG
11 Counseling. I see clients -- when you say --
12 that's at this location. I see clients outside of
13 that location, but my employee is -- my employer is
14 SDG Counseling.
15 BY MS. PHAN:
16 Q Right.
17 A In addition to that, I do have an active real
18 estate broker's license. But when you're talking about
19 counseling and employment, it's SDG Counseling only. I
20 don't work for another counseling center I guess is
21 what -- if you're asking about that.
22 Q Right. That's exactly where I was getting at,
23 if you're still doing any business with Spanish River
24 Counseling.
25 A No. My clients transitioned over to SDG

1 Counseling.
2 Q Are all of your counseling and therapy
3 sessions with SDG in person?
4 MR. MIHET: Form.
5 THE WITNESS: Sometimes I talk on the phone
6 with clients.
7 BY MS. PHAN:
8 Q Do you have any other methods of holding
9 sessions with clients other than the phone and in
10 person?
11 A I don't -- I've never run into that with SDG,
12 no.
13 Q Does SDG currently have a website?
14 A No, ma'am.
15 Q So what -- okay. You mentioned before that
16 you would like to eventually advertise SDG services,
17 correct?
18 A That's correct.
19 Q What does the county's ordinance, in your
20 opinion -- or does it constrict you or restrain you from
21 advertising conversion therapy?
22 MR. MIHET: Form.
23 THE WITNESS: I don't have a copy of the
24 ordinance. I don't have that memorized, I'm sorry.
25 BY MS. PHAN:

1 Q Okay.
2 A Let me take a look at it.
3 MS. PHAN: I'm just giving him a copy of the
4 ordinance.
5 MR. MIHET: Sure. When you deem it
6 appropriate, we could use another break, please.
7 MS. PHAN: Okay.
8 MR. MIHET: Can you read back the last
9 question, please?
10 THE COURT REPORTER: Sure. "What does the
11 county's ordinance, in your opinion -- or does it
12 constrict you or restrain you from advertising
13 conversion therapy?"
14 MR. MIHET: Form, calls for a legal
15 conclusion.
16 THE WITNESS: I'm just taking a quick read
17 through it here, and I don't see that advertising
18 is a violation in the county. I'm missing that on
19 here. Although speech is something that I would
20 like to do, and if you're restricting my ability to
21 speak about it, then advertising would be speech
22 and I can't advertise services that I'm not allowed
23 to provide. And so if you're saying that I'm not
24 allowed to provide a specific service, then I can't
25 legally advertise for that service.

1 BY MS. PHAN:
2 Q Okay. I'd like to go back earlier when you
3 mentioned that you have a client in unincorporated West
4 Boca. Is that client a minor?
5 A No, ma'am.
6 Q Okay. And is SDG and Spanish River Counseling
7 Center affiliated in any way?
8 A No, ma'am.
9 Q Did you ever have any ownership interests in
10 Spanish River Counseling Center?
11 A No, ma'am.
12 Q Were you ever an officer at Spanish River
13 Counseling Center?
14 A No.
15 Q Why did you decide to go into private
16 practice?
17 MR. MIHET: Form.
18 THE WITNESS: When the ordinances were passed
19 and I spoke at the county commission meeting, and
20 then I filed a lawsuit, there is concern that there
21 might be protests at my place of employment and it
22 did not seem advisable to have clients trying to
23 come to talk about their intimate, most personal
24 challenges and have to try to get to the front door
25 through something like that.

1 So in an effort to guard and protect the
2 environment for the clients there, the decision was
3 made that I should be in private practice at that
4 point.
5 BY MS. PHAN:
6 Q Would you say now that SDG and Spanish River
7 Counseling are competitors?
8 A No, ma'am. No.
9 Q So earlier I showed you the -- or I can't
10 remember which exhibit it was, but the consent form for
11 the unwanted same-sex attractions. Is that the same
12 consent form that you use for gender identity confusion
13 as well or is there a different form? Because when your
14 counsel produced it, that was the form that was
15 referenced in regards to the gender identity question as
16 well.
17 MR. MIHET: Form, mischaracterizes counsel's
18 production.
19 THE WITNESS: I have never dealt with gender
20 identity confusion issues. But I could use a
21 bathroom break.
22 MR. MIHET: Me too.
23 THE WITNESS: Would that be okay?
24 MS. PHAN: Yes.
25 THE WITNESS: Thank you very much.

1 (Thereupon, a short break was taken from 2:42
2 p.m. to 2:51 p.m.)
3 BY MS. PHAN:
4 Q So earlier the city's counsel asked you what
5 would you do if a minor wanted counseling so that they
6 can be more comfortable with the same-sex counseling,
7 and you said you would refer them to someone else?
8 A Yes.
9 MR. MIHET: Objection. Form.
10 MS. PHAN: I haven't finished my question.
11 MR. MIHET: I know, but I think you used the
12 word "counseling." Well, just form. Sorry, go
13 ahead.
14 BY MS. PHAN:
15 Q Okay. So I'm just going to repeat it.
16 What would you do if -- so earlier the city's
17 counsel asked you what would you do if a minor client
18 wanted counseling so that he can be more comfortable
19 with same-sex counseling, and you said you would refer
20 them to another specialist or professional, correct?
21 MR. MIHET: Objection. Form, misstates prior
22 testimony.
23 THE WITNESS: Yes. I would refer that client
24 to somebody else.
25 BY MS. PHAN:

1 Q Okay. And you stated that you would give them
2 two names or so of professionals that they can see; is
3 that correct?
4 A I believe I said three.
5 Q Three?
6 A Two or three. Usually I try to give three
7 names.
8 Q Okay. And have you had to do that in the
9 past?
10 A On that particular issue, no; but referring
11 clients to other counselors, absolutely. We pass
12 clients back and forth to the person who addresses the
13 specific issues that that client has a need to do, so
14 that's not an uncommon thing to do in my profession.
15 Q Thank you. Earlier you stated that you had
16 four minor clients that you assisted with unwanted
17 same-sex sexual attractions, whether it's their parents
18 or they want it or whatever it was. On average, how
19 many sessions did the therapy last?
20 MR. MIHET: Form.
21 BY MS. PHAN:
22 Q And if you want to just -- I mean there's only
23 four. If you want to just give me each one, that's fine
24 too.
25 MR. MIHET: Form.

1 THE WITNESS: The first client -- again,
2 taking these in the same order that they were given
3 earlier, okay.
4 The first client I probably saw a half a dozen
5 times off the top of my head. And, again, same-sex
6 attraction was not the primary issue on those.
7 The second client I probably saw a half a
8 dozen times. With the parents, maybe another four
9 times. And, again, these are just guesses off the
10 top of my head, ballpark numbers. And, again, the
11 sexual attraction was not the primary issue in
12 those conversations, although it was a part of
13 conversations.
14 The third client, I saw ███ probably three
15 times with the same comment that sexual attractions
16 was not the primary issue that we were dealing
17 with, although it was a part of the discussion.
18 And the last, my fourth client, I'm going to
19 guess I've seen ███ 12 or 15 times. And, again,
20 some of those had to do with same-sex attractions
21 but most of them did not.
22 BY MS. PHAN:
23 Q Okay. So I'm going to hand you your responses
24 to the county's interrogatories.
25 MR. MIHET: Are we marking this as an exhibit,

1 counsel?
2 MS. PHAN: No.
3 MR. MIHET: Okay.
4 BY MS. PHAN:
5 Q Please look at interrogatory number 3.
6 A I have that much more.
7 Q Okay.
8 A Okay.
9 Q Okay. So you state here or the response
10 states that "Otto focuses on the issues that the client
11 wants to address, including those situations where
12 clients seek assistance in conforming their identity and
13 attractions to their sincerely held religious beliefs,
14 values, and concepts of self."
15 My question to you is: How do you do that?
16 How do you reconcile when there's a conflict between the
17 client's unwanted sexual attraction, sexual orientation
18 with their religious beliefs if there's a conflict?
19 MR. MIHET: Objection. Form, asked and
20 answered.
21 THE WITNESS: Okay. So if a client comes in
22 and says, "Hey, this is what I'm feeling, but this
23 is what I believe," there's a conflict there. So
24 there are three choices: You change one, you
25 change the other, or you learn to live with that

1 conflict in place. And we'll talk about where
2 their priorities are. We'll talk about which one
3 of those is most important to them. We'll talk
4 about maybe the root causes of some of these issues
5 that they're feeling, what they think the root
6 causes are, how much -- to what degree the
7 discomfort is there. Is it just a minor nuisance
8 or is it a significant issue for them?
9 And we'll have conversations. We'll speak
10 about those kinds of things. And as they gain an
11 understanding of their -- as they're able to talk
12 through their feelings and articulate their
13 feelings, oftentimes they're able to come to some
14 resolution about what they think they should do on
15 what things they think they should change or what
16 boundaries they think they should put up or what
17 relationships they think they should modify.
18 And, again, that's all client-driven. That's
19 all directed by what the clients' priorities are
20 and how they bring the issues to the table.
21 BY MS. PHAN:
22 Q Please look at interrogatory number 6.
23 A Okay.
24 Q Okay. So under "Objections," the last
25 sentence of the first paragraph, it says, "Otto is

1 prepared to supplement his response with deposition
2 testimony and otherwise as appropriate in discovery."
3 So my question to you is: Do you have
4 anything to say to supplement your response to
5 interrogatory --
6 MR. MIHET: Let me object as to form and as to
7 the impropriety of asking him about an objection
8 which was made by counsel, not by the client.
9 If you want to ask him questions about this
10 particular topic, he's here to answer them for you
11 today.
12 BY MS. PHAN:
13 Q Please answer my question.
14 MR. MIHET: Go ahead.
15 THE WITNESS: I thought that by coming in and
16 answering questions at the deposition, that was
17 providing a supplemental -- the answers to the
18 questions would be the supplemental information
19 that I mentioned there.
20 BY MS. PHAN:
21 Q So there's nothing you'd like to add to this
22 particular interrogatory number 6?
23 MR. MIHET: Objection. Form. He's here to
24 answer your questions, counsel.
25 MS. PHAN: And that is a question.

1 THE WITNESS: If you have specific questions
2 to me to clarify something or to -- I'd be glad to
3 do that, but I don't have a list of things that I'm
4 ready to recite to you. I thought that's what I
5 put down on paper.
6 BY MS. PHAN:
7 Q Okay. Please look at interrogatory number 7.
8 A Okay.
9 Q In the response in the second paragraph, it
10 states that "Otto shares those beliefs and therapy
11 sessions sometimes include discussions of biblical
12 truths, including that God created men and women, that
13 they are statistically different, and that their design
14 was purposeful." Are there any other biblical truths
15 not included in this response that you would share with
16 your client?
17 MR. MIHET: Objection. Form.
18 THE WITNESS: Can I answer?
19 MR. MIHET: You can answer.
20 THE WITNESS: Okay. Sure. The Bible's a big
21 book, and there's a lot of different conversations
22 that were mentioned earlier today. I can't give
23 one answer that covers all conversations, but
24 certainly it might be something along the lines of,
25 hypothetically, "Children, obey your parents in the

1 Lord, honor your father and mother, treat people
2 with kindness, husbands love your wives as Christ
3 loved the church, consider others as more important
4 than yourselves."
5 There are a lot of biblical truths that would
6 come out in the counseling and covering the
7 different topics that I gave you earlier today that
8 clients come to see me with.
9 BY MS. PHAN:
10 Q Okay. The question though -- question 7 was
11 specific though to same -- or unwanted same-sex
12 attractions or same-sex attractions, not just in general
13 how a parent and child should --
14 MR. MIHET: Is there a question, counselor?
15 BY MS. PHAN:
16 Q Was your response that you just gave in
17 response to the question being asked in interrogatory
18 number 7?
19 MR. MIHET: Form.
20 THE WITNESS: The question I just answered, I
21 thought you were asking what biblical truth would I
22 bring into a counseling session.
23 Specifically with regard to the same-sex
24 attraction issues that we're here today about, the
25 ones that I've listed in my response are the

1 primary ones that I can think of off the top of my
2 head but, again, every conversation with every
3 client is different and perhaps something else
4 would come up that I would talk about, but these
5 are the -- these are the ones that jump at the top
6 of my mind right now.
7 BY MS. PHAN:
8 Q Okay. The next line under that, it says --
9 the response states that "Otto's Christian, Jewish, and
10 Muslim clients all hold the same sincerely held
11 religious beliefs as Otto in this area."
12 Can you tell me what beliefs you're referring
13 to in regards to Muslim clients?
14 A I'm not an expert on Islam, but my
15 understanding from talking with my clients is that they
16 view men and women as distinct and as different from
17 each other, and they view marriage as between a man and
18 a woman, and so those would be the things that I'm
19 referring to there.
20 Q Now you state that your religion -- you're a
21 Christian, correct?
22 A That's correct.
23 Q Is there a specific denomination?
24 A I wouldn't categorize myself in a specific
25 denomination, no.

1 Q And are you a member of a church?
2 A Not right now, no.
3 Q When was the last time you were a member of a
4 church?
5 A Within a year? Four or five years ago, plus
6 or minus.
7 Q Does your religion require you to change
8 minors with unwanted same-sex attractions?
9 MR. MIHET: Objection. Form, assumes facts
10 not in evidence, misstates prior testimony.
11 THE WITNESS: Is that one of the questions
12 here that I'm supposed to refer to?
13 BY MS. PHAN:
14 Q No.
15 A Okay. Does my religion require me to change
16 someone else's sexual preference? Was that the
17 question?
18 Q Yes.
19 A Okay. First of all, I cannot change someone
20 else's sexual preferences, I've already stated that.
21 Second of all, my religion, my Christian faith
22 requires me to be compassionate to people, to show them
23 respect and dignity. So when my client comes and says
24 that I want some help on this particular issue, my
25 Christian faith would say I have the responsibility to

1 help that person on whatever it is causing them
2 distress, and to do that in a way that is honoring to
3 them and shows them dignity and respect and kindness and
4 love and compassion.
5 Q Do you believe that the county's ordinance at
6 issue here requires you to affirm same-sex attractions?
7 MR. MIHET: Objection. Form, calls for a
8 legal conclusion.
9 THE WITNESS: To affirm same-sex attractions?
10 Is that the question?
11 BY MS. PHAN:
12 Q Yes.
13 A Okay. Again, I'm not an attorney. I think
14 the reading of the ordinance says that I cannot help
15 minors with those issues. I don't think it controls --
16 I don't think it says anything about what I can and
17 cannot believe.
18 Q Right. But my question -- I'm asking you your
19 interpretation of the ordinance. In your opinion, do
20 you think that the ordinance requires you to affirm
21 same-sex attractions?
22 A Oh, okay.
23 MR. MIHET: Form, calls for a legal
24 conclusion.
25 THE WITNESS: Okay. No, I don't think it

1 calls for me to affirm anybody's same-sex
2 attraction.
3 BY MS. PHAN:
4 Q If a minor has wanted same-sex attractions,
5 does your religion require you to try to change their
6 same-sex attraction?
7 MR. MIHET: I'm sorry, can you read that one
8 back to me, please?
9 THE COURT REPORTER: "If a minor has wanted
10 same-sex attractions, does your religion require
11 you to try to change their same-sex attraction?"
12 MR. MIHET: Objection. Form, assumes facts
13 not in evidence, misstates prior testimony.
14 THE WITNESS: No, my religion does not require
15 me to do that. And again, as I've said before, I
16 don't think that that's a concept that I can
17 change.
18 BY MS. PHAN:
19 Q Do you believe that identifying as a gender
20 that differs from one's anatomical sex is a sin?
21 A You're asking for a religious answer there.
22 My sincerely held religious beliefs is that God created
23 us as men and women, and they're distinct and purposeful
24 in their creation.
25 Q Do you believe that God designed humans to be

1 heterosexual?
2 A Yes.
3 Q Do you believe that acting on same-sex
4 attractions is a sin?
5 MR. MIHET: Form.
6 THE WITNESS: Yeah, and this is -- you're
7 getting into my personal religious beliefs, which
8 is interesting because I feel like this is -- the
9 ordinance is preventing me from being able to speak
10 openly about my personal sincerely held religious
11 beliefs.
12 Do I think it's a sin to act on homosexual --
13 in homosexual ways? I think that's a violation of
14 what my Bible says. I would say that my Bible says
15 that's a sin.
16 BY MS. PHAN:
17 Q Do you believe that changing same-sex
18 attractions is possible apart from God?
19 MR. MIHET: Objection. Form.
20 THE WITNESS: Oh, I think that people can
21 change in many ways and for many reasons. And so I
22 would say that, sure, there's lots of different
23 ways that people can change or instigators might
24 change or motivations or facilitators.
25 BY MS. PHAN:

1 Q Do you believe that changing gender confusion
2 is possible apart from God?
3 MR. MIHET: Objection. Form.
4 THE WITNESS: I've never dealt with gender
5 confusion in my practice.
6 BY MS. PHAN:
7 Q Can you look at interrogatory number 18,
8 please?
9 A Okay.
10 Q Okay. So you state there that in a typical
11 year prior to the enactment of the ordinance, they
12 accounted for a small part, approximately 5 percent of
13 Otto's practice. They, as in minors, stated goals to
14 conform their sexual attractions, beliefs, or identity.
15 Was that while you were at -- this response is
16 in regards to while you were at Spanish River
17 Counseling, correct?
18 MR. MIHET: I'm going to object. Counsel has
19 misread the response.
20 BY MS. PHAN:
21 Q Okay. I'll re-read it. The response says
22 that "As to minors who present with stated goals to
23 conform their sexual attractions, behaviors, or identity
24 to their sincerely held religious beliefs, values, or
25 concept of self, in a typical year prior to the

1 enactment of the ordinance, they accounted for a small
2 part, approximately 5 percent of Otto's practice." Were
3 you referring to while you were at Spanish River
4 Counseling?
5 A Prior to the enactment of the ordinance I
6 worked at Spanish River Counseling Center, in those few
7 years prior to that, so this answer addresses the
8 clients that I saw at Spanish River Counseling.
9 Q And the 5 percent that you mentioned here,
10 were they exclusively your clients?
11 MR. MIHET: Form.
12 THE WITNESS: I mentioned that I referred the
13 second client in the order that we had them before
14 to another therapist working individually with that
15 person. I remained working with the family.
16 BY MS. PHAN:
17 Q And the 5 percent that is referred here in
18 your response to interrogatory number 18, they -- are
19 they just the four clients that you mentioned before?
20 A That's correct. Yes.
21 MS. PHAN: Okay. Do you have a copy of the
22 Complaint? Otherwise I'm going to show him the --
23 MR. MIHET: No, I don't.
24 BY MS. PHAN:
25 Q So what I'm handing you is a verified copy of

1 the complaint that you filed in this lawsuit, and I'd
2 like for you to look at paragraphs 132 through 135.
3 A Okay.
4 Q From paragraphs 132 through 135, it talks
5 about your minor clients.
6 A Yes.
7 Q Are these the same four clients that we had
8 been discussing?
9 A Yes.
10 Q So in paragraph 132, the clients that we've
11 been speaking of, and we numbered them one through four,
12 132, which client does that apply to?
13 A Okay. 132 is the third client. I'm sorry,
14 the second client I discussed.
15 Q In paragraph 133 --
16 A I'm just reading through this.
17 Q Which client are you referring to?
18 A I'm just trying to keep the order in -- my
19 head in the order here.
20 Q Does it look like that was client number one?
21 A Hang on just a second. Okay. Paragraph 135,
22 that would be my client number three from earlier.
23 Paragraph 134 would be the client number four from
24 earlier. Paragraph 133 -- hang on. I just want to make
25 sure we get these right.

1 Okay. Paragraph 132 is the second client.
2 Okay. Paragraph 133 was the first client. Paragraph
3 134 was the fourth client. And paragraph 135 would be
4 the third client.
5 Q Okay. So earlier when you were speaking of
6 these clients -- let's go through them. I just have a
7 quick question about each of them.
8 So for client number one that we were speaking
9 of, which matches with paragraph 133, when did you first
10 engage in counseling or therapy with this client? And
11 you can just give me the year.
12 A I'm going to guess it was two or two and a
13 half years ago.
14 Q So would you say around 2016?
15 A It was either 2016 or 2017.
16 Q For client number two, when did you first
17 engage in counseling or therapy with this client?
18 A As a landmark, it was probably about nine
19 months before the shooting at the high school in Broward
20 County because that's the way my mind works. You can
21 look up the date for that and go about nine months back,
22 and that was probably ballpark.
23 Q So that was in February. So nine months
24 before February? Which would be --
25 A Just say the beginning of the school year.

1 Q Okay.
2 A Maybe like September or so of the year before
3 that event. And, again, this is just a guess off the
4 top of my head based upon my recollection.
5 Q Same question for client number three. When
6 did you first engage in therapy sessions or counseling
7 with this client?
8 A 2016, 2017, somewhere in there.
9 Q And the same thing with client number four.
10 A Client four would be -- I would guess 18
11 months ago. 18 months ago.
12 Q Okay. Were all four of the minor clients that
13 we're speaking of, were they all located in Boca Raton,
14 Florida?
15 MR. MIHET: Form.
16 THE WITNESS: When you say "located," do you
17 mean is that where I saw them or is that where they
18 resided?
19 BY MS. PHAN:
20 Q Where they resided.
21 A No.
22 Q No? Okay. Can you tell me where they
23 resided?
24 A Spread throughout Palm Beach and Broward
25 County.

1 Q Did you see them outside of your office?
2 MR. MIHET: Form, compound.
3 THE WITNESS: Number four, my fourth client, I
4 have run into ███ outside of the office a few times
5 but not on a professional basis. And the others
6 I've never seen outside the office.
7 BY MS. PHAN:
8 Q Okay. Have you had to turn away potential
9 clients that are minors that had unwanted same-sex
10 attractions --
11 MR. MIHET: Form.
12 BY MS. PHAN:
13 Q -- since the passage of the county's
14 ordinance?
15 MR. MIHET: Form.
16 THE WITNESS: No, I have not.
17 BY MS. PHAN:
18 Q Have you had to terminate any relationships
19 with minors with unwanted same-sex attractions because
20 of the county's ordinance?
21 MR. MIHET: Form.
22 THE WITNESS: No. Clients come in with many
23 issues and the issues that I've needed to talk with
24 clients about and take advantage of talking with
25 clients about since the ordinance passed have not

1 been on unwanted sexual issues.
2 BY MS. PHAN:
3 Q Is change in sexual attractions possible
4 without talk therapy?
5 MR. MIHET: Form.
6 THE WITNESS: I have not met everybody in the
7 world that's changed.
8 BY MS. PHAN:
9 Q In your opinion. In your experience.
10 A People that -- people change for a lot of
11 reasons, some of them because they came to counseling.
12 For a lot of different issues they change. Some change
13 in counseling, some change outside of counseling. I
14 would assume that it is possible. There's nothing that
15 says that counseling is the only reason that people can
16 change.
17 Q To your knowledge, are there continuing
18 learning education courses on conversion therapy
19 practices?
20 A I have no --
21 MR. MIHET: Objection. Form.
22 THE WITNESS: I have no idea.
23 BY MS. PHAN:
24 Q To your knowledge, is there any training on
25 conversion therapy practices?

1 MR. MIHET: Form.
2 THE WITNESS: I have no idea.
3 BY MS. PHAN:
4 Q And when I speak of conversion therapy
5 practices, I mean as defined by the ordinance.
6 A I have no idea.
7 Q Okay. How did you get your training on
8 changing, reducing, or eliminating unwanted same-sex
9 attractions?
10 MR. MIHET: Form, misstates prior testimony,
11 assumes facts not in evidence.
12 THE WITNESS: My training in my master's and
13 my doctorate programs involved helping people with
14 distress in their lives. If they come in dealing
15 with anxiety or depression or confusion because
16 they have things in conflict in their lives, we
17 deal with those issues all the time in the office.
18 BY MS. PHAN:
19 Q At what age do you think a minor can fully
20 consent to counseling and therapy of unwanted same-sex
21 attractions?
22 MR. MIHET: Objection. Form, calls for a
23 legal conclusion.
24 THE WITNESS: Well, I do believe that that
25 Florida Statute says at 13 they can give some kind

1 of consent to counseling within the limitations on
2 that statute. I guess that's my best answer for
3 you.
4 BY MS. PHAN:
5 Q I'm actually asking for your opinion. What do
6 you think?
7 MR. MIHET: Same objections.
8 THE WITNESS: People don't all mature at the
9 same time. The prefrontal cortex doesn't fully
10 develop until the 20s, and boys are a little slower
11 than girls and boys are going to develop
12 differently and, you know, they're unique people,
13 so I don't think that there's a date you can put on
14 a calendar to say that at this point everybody is
15 able to make those mature decisions.
16 BY MS. PHAN:
17 Q Can you look at paragraph 128 of the
18 Complaint?
19 A Yes. Go ahead.
20 Q So in paragraph 128 of the verified complaint,
21 the second sentence states that "This informed consent
22 form outlines the nature of SOCE counseling" -- sorry
23 mine is cut off -- "including the fact that some
24 therapists do not believe sexual orientation can or
25 should be changed and informs the client of the

1 potential benefits and risks associated with SOCE
2 counseling."
3 What risks do you inform your client in
4 regards to SOCE counseling?
5 MR. MIHET: Form.
6 THE WITNESS: Okay. So there is -- how do I
7 articulate this? There's not 100 percent --
8 there's not any kind of treatment that will -- that
9 will never harm anyone I guess is the way to say
10 it. Drugs have adverse side effects. Some people
11 have more than others.
12 Counseling, if I deal with somebody on trauma,
13 you know, that may create a short-term conflict for
14 them and that's a risk. If we put somebody on
15 antidepressants and I'm working with them on
16 depression in conjunction with a psychiatrist,
17 there is an increased risk or potential for
18 suicide. If they have been depressed for a long
19 time and they don't seem to feel better, they have
20 the energy to kill themselves.
21 So there's no therapy or treatment that I've
22 heard of, either medically or counseling, that has
23 no risk involved to it. And so, you know,
24 obviously if somebody is talking about the
25 disconnect between what they -- what they feel and

1 their sincerely held beliefs, if they had kind of
2 kept that stuff down and now they start looking at
3 it where if they were -- if they were, you know,
4 involved in some sort of abuse or unwanted sexual
5 conduct or contact, then to talk about those might
6 create some discomfort for them. And so it's
7 incumbent upon me, as a professional, to be
8 sensitive to those issues to make sure that the
9 clients don't walk out of the office feeling shamed
10 because that would not be beneficial to them.
11 BY MS. PHAN:
12 Q Could you look at interrogatory number 5,
13 please?
14 A Okay.
15 Q Do you have any minor grandchildren?
16 A I do.
17 Q And please tell me their ages if you have more
18 than one.
19 A Less than a year old, just one.
20 Q So is your grandchild showing signs of
21 unwanted same-sex attractions?
22 MR. MIHET: Objection. Misstates -- I'm
23 sorry. Assumes facts not in evidence, misstates
24 the nature of the response, and form.
25 THE WITNESS: He's a baby in diapers.

1 BY MS. PHAN:
2 Q So it's yes or no.
3 A No.
4 Q Okay. Have you provided therapy to your
5 family, anyone in your family, whether it's extended or
6 not, in the past on conversion therapy?
7 MR. MIHET: Form.
8 THE WITNESS: No. When you say "on conversion
9 therapy," I don't practice conversion therapy. I
10 have conversations with people. I've never had a
11 conversation with a family member on changing
12 same-sex attractions or anything like that, so I
13 just want to clarify.
14 BY MS. PHAN:
15 Q Okay.
16 A I don't want you to think that I think that
17 conversion therapy is something that I do with other
18 people but just not with my family members yet.
19 Q Okay. I'd just like to clarify for the record
20 when I was saying "conversion therapy," I meant as
21 defined by the ordinance but also that includes same-sex
22 attractions too.
23 A I understand.
24 MR. MIHET: Objection. Form.
25 THE WITNESS: I understand.

1 MS. PHAN: That wasn't a question.
2 MR. MIHET: Clarifying the prior question,
3 which made it even less clear than before, so
4 objection as to form.
5 BY MS. PHAN:
6 Q Dr. Otto, did you understand what I said
7 before?
8 A I believe so, yes.
9 Q Thank you. So when you have counseling or
10 therapy sessions with minors, you said before that the
11 parents are involved. What is the expectation for
12 maintaining confidentiality for parent disclosures?
13 A Are you asking what I tell the parents or are
14 you asking what I tell the minors that the parents have
15 said to me?
16 Q Both.
17 A Okay. There are -- I start off saying,
18 "Listen, I'm not here to keep secrets from parents."
19 Parents have a responsibility for their minor children
20 and are -- are the ones who provide safety for their
21 minor children.
22 If there are issues of abuse, then obviously
23 that would come up in the counseling or prior to the
24 counseling, and I would adjust accordingly. But
25 assuming that there is no such abuse on file with a

1 complaint to the state or something like that, or
2 suspicion that I would have for abuse, I would not keep
3 secrets from the parents about the children.
4 There are sometimes where children tell me
5 something and they don't want me to tell their parents,
6 so at that point the conversation might shift to "Why
7 don't you want to tell your parents this? What would
8 make it safe or comfortable for you to tell your parents
9 this?" And work to the place where that child could --
10 could have a conversation in a safe and open way with
11 the parent about whatever the uncomfortable topic is.
12 Does that answer your question?
13 Q Yes.
14 A Okay.
15 Q What is the expectation for maintaining
16 confidentiality for child disclosures?
17 MR. MIHET: Form.
18 THE WITNESS: Telling the -- you mean telling
19 the children what the parents have told me?
20 BY MS. PHAN:
21 Q Exactly.
22 A Okay. Well, I don't lie. I'm just trying to
23 think of a way to answer that.
24 I never really found that an issue in
25 counseling where kids have grilled me with what their

1 parents say. They usually know what their parents have
2 said because they probably heard it about 50 or 60 times
3 already and they're tired of hearing it and that's why
4 they're in counseling. So I've never run into a
5 situation where parents have shared something with me
6 and said "Don't tell my kids that I told you this."
7 Well, no, that's not true. Things like "Let them bring
8 it up. They'll bring it up today. They said they
9 wanted to talk with you about it." There are times when
10 kids would bring up the issues, but I've never run into
11 a place where I'm supposed to keep secrets from the kid.
12 Q So like you just said, if the parent says
13 "Don't bring it up, let my son or daughter bring it up
14 instead," so you wouldn't bring it up until the child
15 brought it up, correct?
16 A Yeah. The instances I'm thinking of like that
17 are where the child said "I want to talk about this
18 today when I go to counseling," and the parents kind of
19 gave me a heads-up and maybe some background information
20 on it, and the minor comes in and addresses the issue.
21 Q Okay. But earlier, when we talked about
22 parent disclosures though, you wouldn't keep -- if the
23 minor client told you "Don't tell my parents," you would
24 just tell them in a way -- you would tell the parents
25 but in a way that the child was more comfortable with,

1 correct?
2 MR. MIHET: Form.
3 THE WITNESS: No, I disagree with that.
4 BY MS. PHAN:
5 Q Okay.
6 A There's two issues -- well, a couple of
7 issues. If it's a safety issue, I'm going to tell the
8 parents right then. They need to know. If the child is
9 doing drugs or something or is, you know, drinking and
10 driving, they need to know. All right.
11 If it's not a safety issue and the parents and
12 I have a relationship where they've said "I don't need
13 to know every detail that you talk about," then that
14 gives me a little leeway to have some flexibility in
15 what and when I share with the parents.
16 And it is in my client's benefit for me to
17 work myself out of a job. So if I can help this minor
18 be able to communicate with parents about anything, then
19 the minor does not need to come see me about those
20 issues, "Deal with your parents directly," and that's
21 the goal.
22 So if I can -- whatever the issue is, if I can
23 help the minor address that issue with the parent
24 directly, either in my office or helping the minor learn
25 how to do that at home, in a conversation at home, then

1 there's not an issue of, you know, like keeping secrets
2 back and forth.
3 Q And do you let the child know that that's your
4 policy in regards to disclosure to parents before you
5 begin your sessions?
6 A Well, I said earlier that we usually have
7 everybody in the room at the beginning if they're all
8 comfortable being in the room together and we'll talk
9 through what are our goals, and I'll address the
10 confidentiality limitations at that point.
11 There is my -- the paperwork that you gave me
12 earlier, okay. And a part of that conversation is "I
13 don't keep secrets from your parents and if there's --
14 if there's something that, you know, that you don't want
15 your parents to know and you tell me, you know, I've not
16 found it helpful in working with clients to keep
17 secrets," and I'll explain that to them in a way that
18 says I'll -- like I just did with you about helping them
19 become comfortable sharing that information with their
20 parent, but that's usually done in the initial session
21 so everybody is on the same sheet of music on that.
22 Q Earlier when we talked about the reason why
23 you left Spanish River Counseling to go into your own
24 private practice, was that a voluntary thing that you
25 did?

1 A Yes. It was a discussion between me and the
2 director of the counseling center, and we decided
3 together that that would be beneficial for the clients
4 of the counseling center.
5 Q So in your informed consent form, I believe
6 it's Defendants' Exhibit Number 5, the first paragraph
7 on the second page with the Bates label Otto 009, so the
8 first full sentence, it says, "While your therapist
9 cannot guarantee that for you, you should be informed of
10 the various viewpoints concerning this form of
11 counseling prior to making your decision to choose and
12 pursue such counseling."
13 Do you inform the client of the various
14 viewpoints concerning this form of counseling?
15 A Again, I think that goes in context to the
16 rest of the paragraph. "Your therapist also wants you
17 to know that there are mental health professionals and
18 others who suggest that you should not have the goal of
19 reducing or eliminating your unwanted feelings or
20 attractions, and that some people believe that such
21 counseling is unlikely to assist you. As noted above,
22 your therapist disagrees with such conclusions and has
23 personally counseled many people who experience
24 successful change.
25 While your therapist cannot guarantee that for

1 you, that you will experience successful change, you
2 should be informed of the various viewpoints concerning
3 this form of counseling prior to making your decision to
4 choose or pursue such counseling." So the "that" that
5 is referred to in the sentence that you quoted refers
6 back to successful change. I can't guarantee that my
7 clients will experience the changes they want. Change
8 is possible. They can change. They're very resourceful
9 people.
10 Q Okay. Well, my question was: Do you give
11 them additional information informing them of various
12 viewpoints other than what is already in the consent
13 form?
14 A I would be -- I would give them this form. If
15 you're coming to see me with this issue, I would give
16 you this form.
17 Q So you do not give them -- unless they
18 specifically ask for it, you don't give them other
19 information regarding other viewpoints?
20 A I don't give them a stack of, you know, paper
21 with black clips on it like we had here on the table
22 earlier today, no. They can do their own research. I'm
23 just letting them know that there are people with
24 different opinions on the topic.
25 Q So earlier you mentioned that you've given

1 about two dozen depositions. Have you given any
2 depositions outside of the guardianship cases subject
3 matter?
4 A Off the top of my head, I don't believe so.
5 Q Have you ever gone by any other name than
6 Robert W. Otto?
7 A Robert Otto, Rob Otto. Other than that, no.
8 Q Have you ever been convicted of a felony?
9 A No, ma'am.
10 Q Other than this lawsuit, have you ever been a
11 party in another lawsuit?
12 MR. MIHET: Form.
13 THE WITNESS: Dealing with a mortgage for a
14 house.
15 BY MS. PHAN:
16 Q Is that the only time?
17 A Yes, that I can think of.
18 Q What is your relationship with co-plaintiff
19 Julie Hamilton?
20 MR. MIHET: Form.
21 THE WITNESS: I don't think I met Julie until
22 the Palm Beach County hearing, the first of the two
23 hearings that they had, the county commission
24 hearing.
25 I knew her name from Spanish River Counseling

1 Center, but she had left before I arrived, as I
2 recall. I knew of her. I didn't know what her
3 practice dealt with or what clientele she would
4 deal with. I've talked to her about this lawsuit
5 since we filed it a few times, a few times
6 beforehand, but that's the extent of it.
7 BY MS. PHAN:
8 Q Earlier you spoke about EMDR. Does that stand
9 for eye movement, desensitization, and reprocessing?
10 A Yes, ma'am.
11 Q Do you have to get training or certified in
12 order to practice that?
13 A Yes, ma'am.
14 Q And were you trained?
15 A Yes.
16 Q And are you certified?
17 A Yes.
18 Q Okay. And have you practiced -- and is it a
19 practice? Is it called --
20 MR. MIHET: Form.
21 BY MS. PHAN:
22 Q What's the right --
23 A EMDR, when you're using EMDR with somebody.
24 Q So have you used EMDR on minors with unwanted
25 same-sex attractions?

1 A No. EMDR's proven very helpful for people
2 dealing with trauma and post-traumatic stress issues.
3 I can see cases where it could be helpful in
4 dealing with minors who have experienced trauma and that
5 part of their story is also unwanted same-sex
6 attractions and confusion from that. Where EMDR would
7 be helpful for those clients on the trauma issue, I have
8 not seen any research on its efficacy with same-sex
9 attractions, and I really don't think there would be any
10 connection that would be useful to pursue.
11 Q Can we take a quick five minute break?
12 A Sure.
13 Q I just want to make sure I have everything.
14 (Thereupon, a short break was taken from 3:51
15 p.m. to 4:03 p.m.)
16 BY MS. PHAN:
17 Q Okay. Earlier I asked you about your training
18 in regards to conversion therapy. I wanted to go back
19 to that.
20 So you got your marriage and family therapy
21 degree and master degree and Ph.D from Nova Southeastern
22 University, correct?
23 A That's correct.
24 Q Okay. So did Nova have any specific courses
25 or anything specific in regards to teaching you

1 technique on dealing with sexual orientation change
2 efforts?
3 MR. MIHET: Form.
4 THE WITNESS: No, they didn't.
5 BY MS. PHAN:
6 Q To your knowledge, is there any type of
7 therapy that causes depression, anxiety, suicidal
8 idealization, low self-esteem?
9 MR. MIHET: Form.
10 THE WITNESS: Forms of therapy that would
11 cause that? I'm not sure that question is so
12 informed as to what happens in my office. Let me
13 see if I can give you a picture. If I have
14 somebody coming in --
15 MR. MIHET: She didn't ask you about what
16 happens in your office.
17 THE WITNESS: You're asking about form of
18 therapy that would -- in my profession, I don't
19 think that forms of therapy cause depression. Do
20 clients begin to deal with issues that maybe they
21 had suppressed and then have heightened levels of
22 anxiety or depression as they're working through
23 those issues? Sure, at times. Does that mean that
24 that mode of therapy, whatever it -- off the shelf
25 there's lots of different theories of -- modes of

1 therapy that schools teach. Does that mean that
2 those modes of therapy cause depression? No, I
3 don't think so.
4 BY MS. PHAN:
5 Q To your knowledge, has there been claims that
6 sexual orientation change efforts cause depression,
7 anxiety, suicidal idealization, low self-esteem?
8 MR. MIHET: Form. I have seen some articles
9 that said that there were -- and they're in the
10 request for productions that we gave you, and some
11 of them said that there was evidence that there was
12 discomfort for some clients.
13 The one article I'm thinking about that I read
14 last night, and I can't pull it off the top of my
15 head but it's in the package that you received, but
16 it said that those measures were -- when measured
17 on a scale, they were not significantly impacting
18 the person's life. And so I think the research
19 shows that some people experience perhaps
20 heightened anxiety or discomfort in their lives and
21 other people experience positive change.
22 BY MS. PHAN:
23 Q And speaking of the articles that you provided
24 through the discovery requests, there were several
25 articles related to pornography. What was the reason

1 for providing those articles?
2 MR. MIHET: Objection. Form, calls for a
3 legal conclusion.
4 THE WITNESS: So my whole issue of brain
5 chemistry that I mentioned in one of my
6 interrogatories, our brains are malleable and
7 sexual stimuli certainly programs our brain, and
8 pornography is a clear one to see.
9 If people experience sexual stimuli, it
10 releases chemicals in their brain and those
11 chemicals tend to make us go back to what released
12 those chemicals: Dopamine, oxytocin, vasopressin.
13 And so if you train yourself to go toward
14 pornography, then that becomes natural to you,
15 okay, and that affects your behavior. Research
16 shows that it affects behavior, and research also
17 shows that it affects the way we think. It affects
18 the structure and function of the brain.
19 And so take another sexual influence with say
20 same sex influence, that would release those same
21 chemicals in the brain: Dopamine, oxytocin, and
22 vasopressin, and that would have a similar or
23 comparable programming of the brain in a direction
24 that those influences came from.
25 So can people change? I've had clients who

1 move away from pornography. I've had clients who
2 change their sexual orientation. I didn't move
3 them away from pornography. I didn't change their
4 sexual orientation, but those factors in their
5 lives changed as a result of talking in counseling
6 sessions with me.
7 BY MS. PHAN:
8 Q Okay. I think we're done here. So you can
9 either read --
10 MR. MIHET: I'm sorry, I've got some
11 questions.
12 MS. PHAN: Oh, okay.
13 MR. MIHET: Do you have any more questions?
14 MR. ABBOTT: I do not, not yet.
15 CROSS-EXAMINATION
16 BY MR. MIHET:
17 Q Dr. Otto, not too long ago you answered a
18 question with a statement to the effect of "I don't
19 practice conversion therapy." Do you recall that?
20 A Yes, I do.
21 Q What did you mean by that answer?
22 A Okay. I do not use the term "conversion
23 therapy" to describe what I do. I don't know people
24 that would do something that they would describe with
25 that term of conversion therapy.

1 With that said, the definition in the statute
2 lists some conversations or topics that I might talk
3 about, and I would say that they describe some of the
4 conversations I have with my clients but I'm prohibited
5 from doing that by the statute -- by the ordinances, the
6 city and county ordinances, and I wish to have those
7 conversations with my clients but not prohibited to, and
8 my clients wish to have those conversations with me, but
9 we're prohibited from that.
10 Q Thank you.
11 MR. ABBOTT: Is that it?
12 MR. MIHET: That's it.
13 MR. ABBOTT: Should I ask you if you're going
14 to read or waive or should I have that conversation
15 with Dr. Otto?
16 MR. MIHET: We'll read and sign.
17 (Whereupon, the deposition was concluded at
18 4:09 o'clock p.m.)
19
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24
25

1 CERTIFICATE OF OATH
2
3 STATE OF FLORIDA)
4 COUNTY OF PALM BEACH)
5
6 I, ANGELA CONNOLLY, Registered Professional
7 Reporter, Notary Public, State of Florida, certify that
8 ROBERT W. OTTO, PH.D., LMFT, personally appeared before
9 me and was duly sworn on the 29th day of August, 2018.
10 Signed this 6th day of September, 2018.
11

12
13
14
Angela Connolly, R.P.R.
15 Notary Public, State of Florida
16
17
18 Personally known ______
Produced identification FL DL
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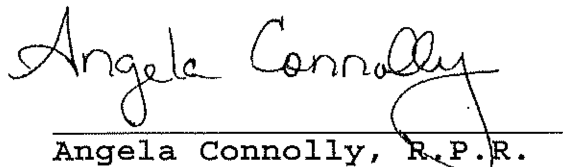
1 CERTIFICATE OF REPORTER
2
3 STATE OF FLORIDA)
4 COUNTY OF PALM BEACH)
5
6 I, ANGELA CONNOLLY, Registered Professional
7 Reporter, certify that I was authorized to and did
8 stenographically report the deposition of ROBERT W.
9 OTTO, PH.D., LMFT; that a review of the transcript was
10 requested; and that the foregoing transcript, Pages 1
11 through 191, is a true record of my stenographic notes.
12 I FURTHER CERTIFY that I am not a relative,
13 employee, or attorney, or counsel of any of the parties,
14 nor am I a relative or employee of any of the parties'
15 attorney or counsel connected with the action, nor am I
16 financially interested in the action.
17 The certification does not apply to any
18 reproduction of the same by any means unless under the
19 direct control and/or direction of the reporter.
20 DATED this 6th day of September, 2018.
21

22
Angela Connolly, R.P.R.
23
24
25

1
2 HORATIO G. MIHET, ESQ.
LIBERTY COUNSEL
3 P.O. BOX 540774
Orlando, FL 32854
4
DATE: September 6, 2018
5

6 In Re: Robert W. Otto, Ph.D., LMFT, and Julie H.
Hamilton, Ph.D., LMFT vs. City of Boca Raton, Florida,
7 and County of Palm Beach, Florida

8
Dear Mr. Mihet:
9
This letter is to inform you that the deposition of
10 ROBERT W. OTTO, PH.D., LMFT, taken on August 29, 2018 in
the above-captioned matter has been completed and is
11 ready for her to read and sign.

12 The transcript is being held in my office. Please make
arrangements with my office so she can read and sign her
13 deposition.

14 Thank you for your prompt attention to this matter.

15

16 Cordially yours,

17
Angela Connolly
18 Registered Professional Reporter

19
cc: Rachel Fahey, Esq.
20 Daniel Abbott, Esq.

21

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23

24

25