

No. 19-10604

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**In the United States Court of Appeals  
for the Eleventh Circuit**

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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.*

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF FLORIDA  
CIV. NO. 18-80771 (HON. ROBIN L. ROSENBERG)

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**SUPPLEMENTAL APPENDIX TO  
BRIEF FOR DEFENDANT-APPELLEE  
CITY OF BOCA RATON, FLORIDA**

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121-19



## “CURES” FOR AN ILLNESS THAT DOES NOT EXIST

### Purported therapies aimed at changing sexual orientation lack medical justification and are ethically unacceptable

#### Introduction

Countless human beings live their lives surrounded by rejection, maltreatment, and violence for being perceived as “different.” Among them, millions are victims of attitudes of mistrust, disdain and hatred because of their sexual orientation. These expressions of homophobia are based on intolerance resulting from blind fanaticism as well as pseudo-scientific views that regard non-heterosexual and non-procreative sexual behavior as “deviation” or the result of a “developmental defect.”

Whatever its origins and manifestations, any form of homophobia has negative effects on the affected people, their families and friends, and society at large. There is an abundance of accounts and testimonies of suffering; feelings of guilt and shame; social exclusion; threats and injuries; and persons who have been brutalized and tortured to the point of causing injuries, permanent scars and even death. As a consequence, homophobia represents a public health problem that needs to be addressed energetically.

While every expression of homophobia is regrettable, harms caused by health professionals as a result of ignorance, prejudice, or intolerance are absolutely unacceptable and must be avoided by all means. Not only is it fundamentally important that every person who uses health services be treated with dignity and respect; it is also critical to prevent the application of theories and models that view homosexuality as a “deviation” or a choice that can

be modified through “will power” or supposed “therapeutic support”.

In several countries of the Americas, there has been evidence of the continued promotion, through supposed “clinics” or individual “therapists,” of services aimed at “curing” non-heterosexual orientation, an approach known as “reparative” or “conversion therapy.”<sup>1</sup> Worryingly, these services are often provided not just outside the sphere of public attention but in a clandestine manner. From the perspective of professional ethics and human rights protected by regional and universal treaties and conventions such as the American Convention on Human Rights and its Additional Protocol (“Protocol of San Salvador”)<sup>2</sup>, they represent unjustifiable practices that should be denounced and subject to corresponding sanctions.

#### Homosexuality as a natural and non-pathological variation

Efforts aimed at changing non-heterosexual sexual orientations lack medical justification since homosexuality cannot be considered a pathological condition.<sup>3</sup> There is a professional consensus that homosexuality represents a natural variation of human sexuality without any intrinsically harmful effect on the health of those concerned or those close to them. In none of its individual manifestations does homosexuality constitute a disorder or an illness, and therefore it requires no cure. For this reason homosexuality was removed

from the relevant systems of classification of diseases several decades ago.<sup>4</sup>

### The ineffectiveness and harmfulness of “conversion therapies”

Besides the lack of medical indication, there is no scientific evidence for the effectiveness of sexual re-orientation efforts. While some persons manage to limit the expression of their sexual orientation in terms of conduct, the orientation itself generally appears as an integral personal characteristic that cannot be changed. At the same time, testimonies abound about harms to mental and physical health resulting from the repression of a person’s sexual orientation. In 2009, the American Psychological Association conducted a review of 83 cases of people who had been subject to “conversion” interventions.<sup>5</sup> Not only was it impossible to demonstrate changes in subjects’ sexual orientation, in addition the study found that the intention to change sexual orientation was linked to depression, anxiety, insomnia, feelings of guilt and shame, and even suicidal ideation and behaviors. In light of this evidence, suggesting to patients that they suffer from a “defect” and that they ought to change constitutes a violation of the first principle of medical ethics: “first, do no harm.” It affects the right to personal integrity as well as the right to health, especially in its psychological and moral dimensions.

### Reported violations of personal integrity and other human rights

As an aggravating factor, “conversion therapies” have to be considered threats to the right to personal autonomy and to personal integrity. There are several testimonies from adolescents who have been subject to “reparative” interventions against their will, many times at their families’ initiative. In

some cases, the victims were interned and deprived of their liberty, sometimes to the extent of being kept in isolation during several months.<sup>6</sup> The testimonies provide accounts of degrading treatment, extreme humiliation, physical violence, aversive conditioning through electric shock or emetic substances, and even sexual harassment and attempts of “reparative rape,” especially in the case of lesbian women. Such interventions violate the dignity and human rights of the affected persons, independently of the fact that their “therapeutic” effect is nil or even counterproductive. In these cases, the right to health has not been protected as demanded by the regional and international obligations established through the Protocol of San

Salvador and the International Covenant on Economic, Social, and Cultural Rights.

### Conclusion

Health professionals who offer “reparative therapies” align themselves with social prejudices and reflect a stark ignorance in matters of sexuality and sexual health. Contrary to what many people believe or assume, there is no reason – with the exception of the stigma resulting from those very prejudices – why homosexual persons should be unable to

enjoy a full and satisfying life. The task of health professionals is to not cause harm and to offer support to patients to alleviate their complaints and problems, not to make these more severe. A therapist who classifies non-heterosexual patients as “deviant” not only offends them but also contributes to the aggravation of their problems. “Reparative” or “conversion therapies” have no medical indication and represent a severe threat to the health and human rights of the affected persons. They constitute unjustifiable practices that should be denounced and subject to adequate sanctions and penalties.

#### The long history of psychopathologization

For centuries, left-handed persons suffered because the use of the left hand (“sinister” in Latin) was thought to be associated with disaster. These people were regarded as carriers of misfortune and as having a “constitutional defect.”

Until relatively recently, there were attempts to “treat” and “correct” this supposed defect, causing suffering, humiliation, learning difficulties and difficulties in adapting to daily life in the affected persons.

## Recommendations

### To governments:

- Homophobic ill-treatment on the part of health professionals or other members of health care teams violates human rights obligations established through universal and regional treaties. Such treatment is unacceptable and should not be tolerated.
- “Reparative” or “conversion therapies” and the clinics offering them should be reported and subject to adequate sanctions.
- Institutions offering such “treatment” at the margin of the health sector should be viewed as infringing the right to health by assuming a role properly pertaining to the health sector and by causing harm to individual and community well-being.<sup>7</sup>
- Victims of homophobic ill-treatment must be treated in accordance with protocols that support them in the recovery of their dignity and self-esteem. This includes providing them treatment for physical and emotional harm and protecting their human rights, especially the right to life, personal integrity, health, and equality before the law.

### To academic institutions:

- Public institutions responsible for training health professionals should include courses on human sexuality and sexual health in their curricula, with a particular focus on respect for diversity and the elimination of attitudes of pathologization, rejection, and hate toward non-heterosexual persons. The participation of the latter in teaching activities contributes to the development of positive role models and to the elimination of common stereotypes about non-heterosexual communities and persons.
- The formation of support groups among faculty and within the student community contributes to reducing isolation and promoting solidarity and relationships of friendship and respect between members of these groups. Better still is the formation of sexual diversity alliances that include heterosexual persons.
- Homophobic harassment or maltreatment on the part of members of the faculty or students is unacceptable and should not be tolerated.

### To professional associations:

- Professional associations should disseminate documents and resolutions by national and international institutions and agencies that call for the de-psychopathologization of sexual diversity and the prevention of interventions aimed at changing sexual orientation.
- Professional associations should adopt clear and defined positions regarding the protection of human dignity and should define necessary actions for the prevention and control of homophobia as a public health problem that negatively impacts the enjoyment of civil, political, economic, social, and cultural rights.
- The application of so-called “reparative” or “conversion therapies” should be considered fraudulent and as violating the basic principles of medical ethics. Individuals or institutions offering these treatments should be subject to adequate sanctions.

### To the media:

- The representation of non-heterosexual groups, populations, or individuals in the media should be based on personal respect, avoiding stereotypes or humor based on mockery, ill-treatment, or violations of dignity or individual or collective well-being.
- Homophobia, in any of its manifestations and expressed by any person, should be exposed as a public health problem and a threat to human dignity and human rights.

- The use of positive images of non-heterosexual persons or groups, far from promoting homosexuality (in virtue of the fact that sexual orientation cannot be changed), contributes to creating a more humane and diversity-friendly outlook, dispelling unfounded fears and promoting feelings of solidarity.
- Publicity that incites homophobic intolerance should be denounced for contributing to the aggravation of a public health problem and threats to the right to life, particularly as it contributes to chronic emotional suffering, physical violence, and hate crimes.
- Advertising by “therapists,” “care centers,” or any other agent offering services aimed at changing sexual orientation should be considered illegal and should be reported to the relevant authorities.

### To civil society organizations:

- Civil society organizations can develop mechanisms of civil vigilance to detect violations of the human rights of non-heterosexual persons and report them to the relevant authorities. They can also help to identify and report persons and institutions involved in the administration of so-called “reparative” or “conversion therapies.”
- Existing or emerging self-help groups of relatives or friends of non-heterosexual persons can facilitate the connection to health and social services with the goal of protecting the physical and emotional integrity of ill-treated individuals, in addition to reporting abuse and violence.
- Fostering respectful daily interactions between persons of different sexual orientations is enriching for everyone and promotes harmonic, constructive, salutary, and peaceful ways of living together.

<sup>1</sup> Human Rights Committee (2008). *Concluding Observations on Ecuador (CCPR/C/Ecuador/CO/5)*, paragraph 12.

<<http://www2.ohchr.org/english/bodies/hrc/docs/co/CCPR.C.ECU.CO.5.doc>>

Human Rights Council (2011). *Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity (A/HRC/19/41)*, paragraph 56. <[http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-41\\_en.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-41_en.pdf)>

Human Rights Council (2011). *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (A/HRC/14/20)*, paragraph 23.

<<http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf>>

United Nations General Assembly (2001). *Note by the Secretary-General on the Question of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (A/56/156)*, paragraph 24. <<http://www.un.org/documents/ga/docs/56/a56156.pdf>>

<sup>2</sup> The human rights that can be affected by these practices include, among others, the right to life, to personal integrity, to privacy, to equality before the law, to personal liberty, to health, and to benefit from scientific progress.

<sup>3</sup> American Psychiatric Association (2000). *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): Position Statement*. <<http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200001.aspx>>

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<<http://www.apa.org/about/governance/council/policy/sexual-orientation.pdf>>

Just the Facts Coalition (2008). *Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*. Washington, DC. <<http://www.apa.org/pi/lgbt/publications/justthefacts.html>>

<sup>4</sup> World Health Organization (1994). *International Statistical Classification of Diseases and Related Health Problems (10<sup>th</sup> Revision)*. Geneva, Switzerland.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed., text revision)*. Washington, DC.

<sup>5</sup> APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC. <<http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>>

<sup>6</sup> Taller de Comunicación Mujer (2008). *Pacto Internacional de Derechos Civiles y Políticos: Informe Sombra*. <<http://www.tcmujer.org/pdfs/Informe%20Sombra%202009%20LBT.pdf>>

Centro de Derechos Económicos y Sociales (2005). *Tribunal por los Derechos Económicos, Sociales y Culturales de las Mujeres*.

<<http://www.tcmujer.org/pdfs/TRIBUNAL%20DESC%20ECUADOR%20MUJERES.pdf>>

<sup>7</sup> See General Comment No. 14 by the Committee on Economic, Social, and Cultural Rights with regards to the obligation to respect, protect and comply with human rights obligations on the part of States parties to the International Covenant on Economic, Social, and Cultural Rights.

Tab.  
121-26

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**RESPONSE:** Denied.

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

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

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

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

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

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

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

**RESPONSE:** Admitted.

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

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

22. Admit that minors are a particularly vulnerable population.

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

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

**RESPONSE:** Admitted.

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

**RESPONSE:** Admitted.

25. Admit that rejection can harm minors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

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

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

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

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

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

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

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

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

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

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

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

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

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

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

/s/ Horatio G. Mihet  
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**CERTIFICATE OF SERVICE**

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

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Horatio G. Mihet

Attorney for Plaintiffs

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

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

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

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

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

**RESPONSE:** Denied.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**RESPONSE:** Denied.

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

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

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

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

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

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

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

**RESPONSE:** Admitted.

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

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

23. Admit that minors are a particularly vulnerable population.

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

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

**RESPONSE:** Admitted.

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

**RESPONSE:** Admitted.

26. Admit that rejection can harm minors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a client willingly and actively pursues.

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

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

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

**RESPONSE:** Denied.

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

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

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

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

46. Admit that County's ordinance 2017-046 does not reference any religion.

**RESPONSE:** Denied.

47. Admit that County's ordinance 2017-046 does not reference any religious practice or conduct.

**RESPONSE:** Denied.

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

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

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

**RESPONSE:** Otto objects to this request because it seeks an admission on matters not relevant to any issues in this lawsuit. Otto further objects to this request because it misstates the practice of licensed marriage and family therapists and is based on a false assumption and premise. Notwithstanding, Otto denies the implication that a minor's gender identity is rigid and unchangeable, denies that a minor's gender identity can never change, and

denies that Otto cannot safely and effectively assist minors in understanding themselves and making the changes that the minors desire for their lives.

50. Admit that psychological harms may take years to manifest or be identified.

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

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

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

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**CERTIFICATE OF SERVICE**

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

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Tab.  
128-2

## Homosexuality and Adolescence

Committee on Adolescence

The American Academy of Pediatrics issued its first statement on homosexuality and adolescence in 1983. The past decade has witnessed increased awareness of homosexuality, changing attitudes toward this sexual orientation, and the growing impact of the human immunodeficiency virus (HIV). Therefore, an updated statement on homosexuality and adolescence is timely.

Homosexuality is the persistent sexual and emotional attraction to members of one's own gender and is part of the continuum of sexual expression. Many gay and lesbian youths first become aware of and experience their sexuality during adolescence. Therefore, pediatricians who care for teenagers need to understand the unique medical and psychosocial issues facing homosexually oriented youths (see Table 1 for a definition of terms).

### ETIOLOGY AND PREVALENCE

Homosexuality has existed in most societies for as long as recorded descriptions of sexual beliefs and practices have been available. Societal attitudes toward homosexuality have had a decisive impact on the extent to which individuals have hidden or made known their sexual orientation.

In 1973, the American Psychiatric Association reclassified homosexuality as a sexual orientation/expression rather than as a mental disorder.<sup>1</sup> The etiology of homosexuality remains unclear, but the current literature and the vast majority of scholars in this field state that one's sexual orientation is not a choice, that is, individuals no more choose to be homosexual than heterosexual.<sup>2,3</sup> However, the expression of sexual behaviors and lifestyle is a choice for all teenagers regardless of sexual orientation.

During the adolescent years, many youths engage in sexual experimentation. Sexual behavior during this period does not predict future sexual orientation. Gay, lesbian, and heterosexual youths may engage in sexual activities with members of the same or opposite sex. Kinsey et al,<sup>4,5</sup> from their studies in the 1930s and 1940s, reported that 37% of men had at least one homosexual experience resulting in orgasm. From the same cohort, Kinsey reported that 4% of women and 10% of men were exclusively homosexual for at least 3 years of their lives. Sorenson<sup>6</sup> surveyed a group of 16- to 19-year-olds and reported that 6% of

females and 17% of males had at least one homosexual experience. While the Kinsey data suggest that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies, the current prevalence of homosexual behavior and identity among adolescents remains to be defined.

### SPECIAL CONCERNS

Gay and lesbian adolescents share many of the developmental tasks of their heterosexual peers. These include establishing a sexual identity and deciding on sexual behaviors, whether choosing to engage in sexual intercourse or to abstain. Due to the seriousness of sexually transmitted diseases (STDs), abstinence should be promoted as the safest choice for all adolescents. However, not all youths will choose abstinence. The current reality is that a large number of adolescents are sexually active. Therefore, all adolescents should receive sexuality education and have access to health care resources. It is important to provide appropriate anticipatory guidance to all youths regardless of their sexual orientation. Physicians must also be aware of the important medical and psychosocial needs of gay and lesbian youths.<sup>7</sup>

### HIV

The epidemic of the HIV infection highlights the urgency of making preventive services and medical care available to all adolescents regardless of sexual orientation or activity. Heterosexual and homosexual transmission of HIV infection is well established. The role of injectable drugs of abuse in HIV transmission is also well known.<sup>3,8</sup> Sex between males accounts for about half of the non-transfusion-associated cases of acquired immunodeficiency syndrome (AIDS) among males between the ages of 13 and 19 years.<sup>8</sup> While not all gay adolescents engage in high-risk sex (or even have sex), their vulnerability to HIV infection is well recognized. The pediatrician should encourage adolescents to practice abstinence. However, many will not heed this important message. Thus, practical, specific advice about condom use and other forms of safer sex should be included in all sexuality education and prevention discussions.

### Issue of Trust

Quality care can be facilitated if the pediatrician recognizes the specific challenges and rewards of providing services for gay and lesbian adolescents. This care begins with the establishment of trust, respect, and confidentiality between the pediatrician and the adolescent. Many gay and lesbian youths avoid health care or discussion of their sexual orientation out of fear that their sexual orientation will be

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this policy statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations taking into account individual circumstances, may be appropriate.

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**TABLE 1.** Definitions of Terms

Coming out	The acknowledgment of one's homosexuality and the process of sharing that information with others.
Gender identity	The personal sense of one's integral maleness or femaleness; typically occurs by 3 years of age.
Gender role	The public expression of gender identity; the choices and actions that signal to others a person's maleness or femaleness; one's sex role.
Heterosexist bias	The conceptualization of human experience in strictly heterosexual terms and consequently ignoring, invalidating, or derogating homosexual behaviors and sexual orientation. <sup>19</sup>
Homophobia	The irrational fear or hatred of homosexuality, which may be expressed in stereotyping, stigmatization, or social prejudice <sup>18</sup> ; it may also be internalized in the form of self-hatred.
In the closet	Nondisclosure or hiding one's sexual orientation from others.
Sexual orientation	The persistent pattern of physical and/or emotional attraction to members of the same or opposite sex. Included in this are homosexuality (same-gender attractions); bisexuality (attractions to members of both genders); and heterosexuality (opposite-gender attractions). The terms preferred by most homosexuals today are lesbian women or gay men.
Transsexual	An individual who believes himself or herself to be of a gender different from his or her assigned biologic gender (gender identity does not match anatomic gender).
Transvestite	An individual who dresses in the clothing of the opposite gender and derives pleasure from this action. This is not indicative of one's sexual orientation.

disclosed to others. The goal of the provider is not to identify all gay and lesbian youths, but to create comfortable environments in which they may seek help and support for appropriate medical care while reserving the right to disclose their sexual identity when ready. Pediatricians who are not comfortable in this regard should be responsible for seeing that such help is made available to the adolescent from another source.

#### SPECIAL ASPECTS OF CARE

##### History

A sexual history that does not presume exclusive heterosexuality should be obtained from all adolescents.<sup>3,9</sup> Confidentiality must be emphasized except in cases in which sexual abuse has occurred. It is vital to identify high-risk behavior (anal or vaginal coitus, oral sex, casual and/or multiple sex partners, substance abuse, and others).

##### Physical Examination

A thorough and sensitive history provides the groundwork for an accurate physical examination for youths who are sexually experienced.<sup>10</sup> Depending on the patient's sexual practices, a careful examination includes assessment of pubertal staging, skin lesions (including cutaneous manifestations of STDs, bruising, and other signs of trauma), lymphadenopathy (including inguinal), and anal pathology (including discharge, venereal warts, herpetic lesions, fissures, and others). Males need evaluation of the penis (ulcers, discharge, skin lesions), scrotum, and prostate (size, tenderness). Females need assessment of their breasts, external genitalia, vagina, cervix, uterus, and adnexa.

##### Laboratory Studies

All males engaging in sexual intercourse with other males should be routinely screened for STDs, including gonorrhea, syphilis, chlamydia, and enteric pathogens. The oropharynx, rectum, and urethra should be examined and appropriate cultures obtained when indicated.<sup>3,9</sup>

Immunity to hepatitis B virus should be assessed. Immunization is recommended for all sexually active adolescents and should be provided for all males

who are having or anticipate having sex with other males.<sup>11</sup> HIV testing with appropriate consent should be offered; this includes counseling before and after voluntary testing.

Women who have sex exclusively with other women have a low incidence of STDs, but can transmit STDs and potentially HIV if one partner is infected. Since lesbian women who engage in unprotected sex with men face risks of both sexually acquired infections and pregnancy, the pediatrician should offer them realistic birth control information and counseling on STD prevention.

#### PSYCHOSOCIAL ISSUES

The psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred, and isolation.<sup>12</sup> The gravity of these stresses is underscored by current data that document that gay youths account for up to 30% of all completed adolescent suicides.<sup>13</sup> Approximately 30% of a surveyed group of gay and bisexual males have attempted suicide at least once.<sup>14</sup> Adolescents struggling with issues of sexual preference should be reassured that they will gradually form their own identity<sup>15</sup> and that there is no need for premature labeling of one's sexual orientation.<sup>16</sup> A theoretical model of stages for homosexual identity development composed by Troiden<sup>17</sup> is summarized in Table 2. The health care professional should explore each adolescent's perception of homosexuality, and any youth struggling with sexual orientation issues should be offered appropriate referrals to providers and programs that can affirm the adolescent's intrinsic worth regardless of sexual identity. Providers who are unable to be objective because of religious or other personal convictions should refer patients to those who can.

Gay or lesbian youths often encounter considerable difficulties with their families, schools, and communities.<sup>16,18,19</sup> These youths are severely hindered by societal stigmatization and prejudice, limited knowledge of human sexuality, a need for secrecy, a lack of opportunities for open socialization, and limited communication with healthy role models. Subjected to overt rejection and harassment at the hands of family members, peers, school officials, and others

**TABLE 2.** Stages of Homosexual Identity Formation\*

Sensitization	The feeling of differentness as a prepubertal child or adolescent. The first recognition of attraction to members of the same gender before or during puberty.
Sexual identity confusion	Confusion and turmoil stemming from self-awareness of same-gender attractions. Often this first occurs during adolescence. This confusion usually is not so much due to a questioning of one's feelings as it is to the attempt to reconcile the feelings with negative societal stereotypes. The lack of accurate knowledge about homosexuality, the scarcity of positive gay and lesbian role models, and the absence of an opportunity for open discussion and socialization as a gay or lesbian person contribute to this confusion. During this stage the adolescent develops a coping strategy to deal with social stigma.
Sexual identity assumption	The process of acknowledgment and social and sexual exploration of one's own gay or lesbian identity and consideration of homosexuality as a lifestyle option. This stage typically persists for several years during and after late adolescence.
Integration and commitment	The stage at which a gay or lesbian person incorporates his/her homosexual identity into a positive self-acceptance. This gay or lesbian identity is then increasingly and confidently shared with selected others. Many gays and lesbians may never reach this stage; those who do are typically in adulthood when this acceptance occurs.

\* From Troiden.<sup>17</sup>

in the community, they may seek, but not find, understanding and acceptance by parents and others. Parents may react with anger, shock, and/or guilt when learning that their child is gay or lesbian.

Peers may engage in cruel name-calling, ostracize, or even physically abuse the identified individual. School and other community figures may resort to ridicule or open taunting, or they may fail to provide support. Such rejection may lead to isolation, runaway behavior, homelessness, domestic violence, depression, suicide, substance abuse, and school or job failure. Heterosexual and/or homosexual promiscuity may occur, including involvement in prostitution (often in runaway youths) as a means to survive. Pediatricians should be aware of these risks and provide or refer such youths for appropriate counseling.

#### Disclosure

The gay or lesbian adolescent should be allowed to decide when and to whom to disclose his/her sexual identity. In particular, the issue of informing parents should be carefully explored so that the adolescent is not exposed to violence, harassment, or abandonment. Parents and other family members may derive considerable benefit and gain understanding from organizations such as Parents and Friends of Lesbians and Gays (PFLAG).<sup>3,18</sup>

#### Concept of Therapy

Confusion about sexual orientation is not unusual during adolescence. Counseling may be helpful for young people who are uncertain about their sexual orientation or for those who are uncertain about how to express their sexuality and might profit from an attempt at clarification through a counseling or psychotherapeutic initiative. Therapy directed specifically at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation. While there is no current literature clarifying whether sexual abuse can induce confusion in one's sexual orientation, those with a history of sexual abuse should always receive counseling with appropriate mental health specialists. Therapy may also be helpful in addressing personal, family, and environmental difficulties that are often concomitants of the emerging expression of homosexuality.

Family therapy may also be useful and should always be made available to the entire family when major family difficulties are identified by the pediatrician as parents and siblings cope with the potential added strain of disclosure.

#### SUMMARY OF PHYSICIAN GUIDELINES

Pediatricians should be aware that some of the youths in their care may be homosexual or have concerns about sexual orientation. Caregivers should provide factual, current, nonjudgmental information in a confidential manner. These youths may present to physicians seeking information about homosexuality, STDs, substance abuse, or various psychosocial difficulties. The pediatrician should ensure that each youth receives a thorough medical history and physical examination (including appropriate laboratory tests), as well as STD (including HIV) counseling and, if necessary, appropriate treatment. The health care professional should also be attentive to various potential psychosocial difficulties and offer counseling or refer for counseling when necessary.

The American Academy of Pediatrics reaffirms the physician's responsibility to provide comprehensive health care and guidance for all adolescents, including gay and lesbian adolescents and those young people struggling with issues of sexual orientation. The deadly consequences of AIDS and adolescent suicide underscore the critical need to address and seek to prevent the major physical and mental health problems that confront gay and lesbian youths in their transition to a healthy adulthood.

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**Homosexuality and Adolescence**  
*Pediatrics* 1993;92:631

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**Homosexuality and Adolescence**  
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Tab.  
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APA Official Actions

## Position Statement on Psychiatric Treatment and Sexual Orientation

Approved by the Board of Trustees, December 1998  
Approved by the Assembly, November 1998

"Policy documents are approved by the APA Assembly and Board of Trustees... These are... position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

The Board of Trustees of the American Psychiatric Association (APA) removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 after reviewing evidence that it was not a mental disorder. In 1987 ego-dystonic homosexuality was not included in the revised third edition of DSM (DSM-II-R) after a similar review.

APA does not currently have a formal position statement on treatments that attempt to change a person's sexual orientation, also known as "reparative therapy" or "conversion therapy." In 1997 APA produced a fact sheet on homosexual and bisexual issues, which states that "there is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation."

The potential risks of "reparative therapy" are great and include depression, anxiety, and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone "reparative therapy" relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility

that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian are not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. APA recognizes that in the course of ongoing psychiatric treatment, there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations, including the American Psychological Association, the National Association of Social Workers, and the American Academy of Pediatrics, have made statements against "reparative therapy" because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice, and unethical treatment on a variety of issues, including discrimination on the basis of sexual orientation.

Therefore, APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.

*An initial version of this position statement was proposed in September 1998 by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs. It was revised and approved by the APA Assembly in November 1998. The revised version was approved by the Board of Trustees in December 1998. The committee members as of September 1998 were Lowell D. Tong, M.D. (chairperson), Leslie G. Goransson, M.D., Mark H. Townsend, M.D., Diana C. Miller, M.D., Cheryl Ann Clark, M.D., Kenneth Ashley, M.D. (consultant); corresponding members: Stuart M. Sotsky, M.D., Howard C. Rubin, M.D., Daniel W. Hicks, M.D., Ronald L. Cowan, M.D.; Robert J. Mitchell, M.D. (Assembly liaison), Karine Igartua, M.D. (APA/Glaxo Wellcome Fellow), Steven Lee, M.D. (APA/Bristol-Myers Squibb Fellow), and Petros Levounis, M.D. (APA/Center for mental Health Services Fellow).*

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Defendant/City of Boca Raton's Trial  
Exhibit No. 3  
Otto, et al vs. City of Boca Raton, et al  
Case No. 18-cv-80771

City - 0018

Tab.  
128-5



# Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

## RESEARCH SUMMARY

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammer-smith, 1981; Bullough, 1976; Ford & Beach, 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of *sexual orientation change efforts* (SOCE).<sup>1</sup> SOCE has been controversial due to tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006). Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty

Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008b).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the Association. The Task Force reached the following findings.

Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002, Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them to change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socio-economic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orien-



on August 5, 2009.

For more information, please see [www.apa.org/pi/lgbt](http://www.apa.org/pi/lgbt).

## PLEASE CITE AS:

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## Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

tation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the Task Force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities<sup>2</sup> (Herek, 2009; Herek & Garnets, 2007) and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA, 1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

## RESOLUTION

WHEREAS the American Psychological Association (APA) expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008b); and

WHEREAS the APA takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008b); and

WHEREAS psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008b); and

WHEREAS psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008b); and

WHEREAS those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008b); and

WHEREAS the APA encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008b); and

WHEREAS societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001); and

WHEREAS some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968); and

WHEREAS sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perin, 2002; Ryan & Futterman, 1997), who lack adequate legal protection from involuntary or coercive treatment (Arriola,

## Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciotto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hershberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE BE IT RESOLVED that the APA affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED that the APA reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED that the APA encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED that the APA concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents, and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED that the APA advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as

a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED that the APA encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity;

BE IT FURTHER RESOLVED that the APA encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma, and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED that the APA opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED that the APA supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation;

BE IT FURTHER RESOLVED that the APA encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the wellbeing of sexual minorities.

## Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts

## ENDNOTES

1. The APA uses the term *sexual orientation change efforts* to describe all means to change sexual orientation (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches). This includes those efforts by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups.
2. The Task Force uses the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because the Task Force recognizes that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

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Tab.  
128-6

## **2012 - Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression**

The American Psychoanalytic Association affirms the right of all people to their sexual orientation, gender identity and gender expression without interference or coercive interventions attempting to change sexual orientation, gender identity or gender expression.

As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to “convert,” “repair,” change or shift an individual’s sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.

*Adopted June 2012. This position statement replaces APsaA’s December 1999 position statement on reparative therapy*

Tab.

128-18

### Consent-to-Treat and Financial Agreement

Upon initiating therapy services, it is important for you to be aware of the following information:

**CONFIDENTIALITY:** Statements that are made by a client to a psychotherapist are generally confidential; however, there are some exceptions which may lead to a waiver of the psychotherapist-client privilege and disclosure of otherwise confidential information. The exceptions include:

1. If you threaten to harm yourself;
2. If you make a serious threat to harm a readily ascertainable third party;
3. If you disclose instances of child abuse, elder abuse, or dependent adult abuse. Abuse includes but is not limited to physical abuse, sexual abuse, or neglect. For further information on what constitutes abuse or neglect please refer to Florida state law;
4. If you tender your mental condition in a lawsuit or criminal proceeding;
5. If the therapist is required by a court order to disclose your records;
6. If there is an action which alleges that there is a breach of duties running between psychotherapist and client; and
7. If each individual involved in the therapy sessions gives written permission to disclose information to a specific party.

Hamilton 005

I understand that my therapist may consult with other professionals, who are also required to maintain confidentiality, to ensure the provision of effective treatment services. I understand that this consultation will not compromise my identify or confidentiality.

Initial \_\_\_\_\_

**EMERGENCIES:** Due to the nature of this practice, 24-hour emergency access is not available. In the case of emergencies, please call 911.

Initial \_\_\_\_\_

**NO GUARANTEE OF SUCCESS:** Because there are many variables in psychotherapy, there is no guarantee that by pursuing psychotherapy the client will be happier, and no particular treatment can be guaranteed to be effective. Therapy also requires the active participation of the client, and that the client be truthful with the psychotherapist.

Initial \_\_\_\_\_

**NATURE OF PSYCHOTHERAPY:** Sometimes the psychotherapeutic process can bring up uncomfortable feelings such as anxiety, sadness, anger, and so on; please be aware that this is a normal response to talking about unresolved life experiences.

**LENGTH OF SESSION AND FINANCIAL INFORMATION:** Therapy sessions last approximately 50 minutes. The fee for therapy is \$100.00 per session, payable at the end of each session.

Initial \_\_\_\_\_

**CANCELLATION POLICY:** If you need to cancel or reschedule an appointment, please allow for 24 hours notice. Cancellations made less than 24 hours ahead of the appointment time will be charged the session fee.

Initial \_\_\_\_\_

**TELEPHONE THERAPY:** Psychotherapy is typically in the form of regularly scheduled, face-to-face, individual sessions. For that reason, office-based counseling is generally recommended.

However, some clients are unable to find a suitable therapist in their geographical area, and therefore they decide to conduct at least some therapy in the form of telephone consultations.

It is important for the client to recognize the following: that there is some controversy regarding the use of telephone therapy, including concerns that confidentiality cannot be guaranteed when communicating by phone or internet; that the therapist is unable to assess the client's demeanor by telephone; that telephone consultations are educational, but may not be as effective as face-to-face sessions; and that supplementary, face-to-face therapy or transfer to another psychotherapist may be necessary if the client should experience severe emotional disturbance, such as anxiety or depression.

In addition, this therapist is licensed in the state of Florida. If telephone therapy is provided to clients outside of the state of Florida, it is important to note that some states do not allow the delivery of services across state lines. For clients living in states that prohibit telephone therapy across state lines, this therapist will be unable to provide services.

Initial \_\_\_\_\_

Hamilton 006

**MERGER AGREEMENT:** All prior negotiations and representations are subsumed in this document and merged herein.

Initial \_\_\_\_\_

I understand that I am responsible for any all and indebtedness incurred as a result of services rendered. I understand that I have a right to terminate services at any time. I agree to hold harmless my therapist from any claim for damages of any nature arising out of, or allegedly due to, any therapy, counseling or service rendered. I accept full responsibility for any decision I make regarding my life. I have read the above information carefully, understand its contents, and agree, under these conditions, to receive therapy and services for myself and/or anyone herein designated.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Tab.  
128-21

# Code of Ethics

## PREAMBLE

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective January 1, 2015.

### Honoring Public Trust

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee.

### Commitment to Service, Advocacy and Public Participation

Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Marriage and family therapists embody these aspirations by participating in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the character of the field, and to the well-being of clients and their communities.

### Seeking Consultation

The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

### Ethical Decision-Making

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional

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Defendant/City of Boca Raton's Trial

Exhibit No. 24

Otto, et al vs. City of Boca Raton, et al

Case No. 18-cv-80771

behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and take reasonable steps to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

## **Binding Expectations**

The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories, all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

## **Resolving Complaints**

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

## **Aspirational Core Values**

The following core values speak generally to the membership of AAMFT as a professional association, yet they also inform all the varieties of practice and service in which marriage and family therapists engage. These core values are aspirational in nature, and are distinct from ethical standards. These values are intended to provide an aspirational framework within which marriage and family therapists may pursue the highest goals of practice.

The core values of AAMFT embody:

1. Acceptance, appreciation, and inclusion of a diverse membership.
2. Distinctiveness and excellence in training of marriage and family therapists and those desiring to advance their skills, knowledge and expertise in systemic and relational therapies.
3. Responsiveness and excellence in service to members.
4. Diversity, equity and excellence in clinical practice, research, education and administration.
5. Integrity evidenced by a high threshold of ethical and honest behavior within Association governance and by members.
6. Innovation and the advancement of knowledge of systemic and relational therapies.

## **Ethical Standards**

Ethical standards, by contrast, are rules of practice upon which the marriage and family therapist is obliged and judged. The introductory paragraph to each standard in the AAMFT Code of Ethics is an aspirational/explanatory orientation to the enforceable standards that follow.

## STANDARD I

### RESPONSIBILITY TO CLIENTS

*Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system.*

#### **1.1 Non-Discrimination.**

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

#### **1.2 Informed Consent.**

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented.

#### **1.3 Multiple Relationships.**

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

#### **1.4 Sexual Intimacy with Current Clients and Others.**

Sexual intimacy with current clients or with known members of the client's family system is prohibited.

#### **1.5 Sexual Intimacy with Former Clients and Others.**

Sexual intimacy with former clients or with known members of the client's family system is prohibited.

#### **1.6 Reports of Unethical Conduct.**

Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

#### **1.7 Abuse of the Therapeutic Relationship.**

Marriage and family therapists do not abuse their power in therapeutic relationships.

### **1.8 Client Autonomy in Decision Making.**

Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

### **1.9 Relationship Beneficial to Client.**

Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

### **1.10 Referrals.**

Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help.

### **1.11 Non-Abandonment.**

Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.

### **1.12 Written Consent to Record.**

Marriage and family therapists obtain written informed consent from clients before recording any images or audio or permitting third-party observation.

### **1.13 Relationships with Third Parties.**

Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

## **STANDARD II**

## **CONFIDENTIALITY**

*Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.*

### **2.1 Disclosing Limits of Confidentiality.**

Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

### **2.2 Written Authorization to Release Client Information.**

Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency

situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

### **2.3 Client Access to Records.**

Marriage and family therapists provide clients with reasonable access to records concerning the clients. When providing couple, family, or group treatment, the therapist does not provide access to records without a written authorization from each individual competent to execute a waiver. Marriage and family therapists limit client's access to their records only in exceptional circumstances when they are concerned, based on compelling evidence, that such access could cause serious harm to the client. The client's request and the rationale for withholding some or all of the record should be documented in the client's file. Marriage and family therapists take steps to protect the confidentiality of other individuals identified in client records.

### **2.4 Confidentiality in Non-Clinical Activities.**

Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Standard 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

### **2.5 Protection of Records.**

Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

### **2.6 Preparation for Practice Changes.**

In preparation for moving a practice, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

### **2.7 Confidentiality in Consultations.**

Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

## **STANDARD III**

## **PROFESSIONAL COMPETENCE AND INTEGRITY**

*Marriage and family therapists maintain high standards of professional competence and integrity.*

### **3.1 Maintenance of Competency.**

Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.

### **3.2 Knowledge of Regulatory Standards.**

Marriage and family therapists pursue appropriate consultation and training to ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards.

### **3.3 Seek Assistance.**

Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment.

### **3.4 Conflicts of Interest.**

Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

### **3.5 Maintenance of Records.**

Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

### **3.6 Development of New Skills.**

While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, and/or supervised experience.

### **3.7 Harassment.**

Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

### **3.8 Exploitation.**

Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

### **3.9 Gifts.**

Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship.

### **3.10 Scope of Competence.**

Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

### **3.11 Public Statements.**

Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

### **3.12 Professional Misconduct.**

Marriage and family therapists may be in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to

their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

## STANDARD IV

### RESPONSIBILITY TO STUDENTS AND SUPERVISEES

*Marriage and family therapists do not exploit the trust and dependency of students and supervisees.*

#### **4.1 Exploitation.**

Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

#### **4.2 Therapy with Students or Supervisees.**

Marriage and family therapists do not provide therapy to current students or supervisees.

#### **4.3 Sexual Intimacy with Students or Supervisees.**

Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee.

#### **4.4 Oversight of Supervisee Competence.**

Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

#### **4.5 Oversight of Supervisee Professionalism.**

Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

#### **4.6 Existing Relationship with Students or Supervisees**

Marriage and family therapists are aware of their influential positions with respect to supervisees, and they avoid exploiting the trust and dependency of such persons. Supervisors, therefore, make every effort to avoid conditions and multiple relationships with supervisees that could impair professional judgment or increase the risk of exploitation. Examples of such relationships include, but are not limited to, business or close personal relationships with supervisees or the supervisee's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, supervisors document the appropriate precautions taken.

#### **4.7 Confidentiality with Supervisees.**

Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

#### **4.8 Payment for Supervision.**

Marriage and family therapists providing clinical supervision shall not enter into financial arrangements with supervisees through deceptive or exploitative practices, nor shall marriage and family therapists providing clinical supervision exert undue influence over supervisees when establishing supervision fees. Marriage and family therapists shall also not engage in other exploitative practices of supervisees.

## **STANDARD V RESEARCH AND PUBLICATION**

*Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.*

#### **5.1 Institutional Approval.**

When institutional approval is required, marriage and family therapists submit accurate information about their research proposals and obtain appropriate approval prior to conducting the research.

#### **5.2 Protection of Research Participants.**

Marriage and family therapists are responsible for making careful examinations of ethical acceptability in planning research. To the extent that services to research participants may be compromised by participation in research, marriage and family therapists seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

#### **5.3 Informed Consent to Research.**

Marriage and family therapists inform participants about the purpose of the research, expected length, and research procedures. They also inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate such as potential risks, discomforts, or adverse effects. Marriage and family therapists are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children. Marriage and family therapists inform participants about any potential research benefits, the limits of confidentiality, and whom to contact concerning questions about the research and their rights as research participants.

#### **5.4 Right to Decline or Withdraw Participation.**

Marriage and family therapists respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation. When offering inducements for research participation, marriage and family therapists make reasonable efforts to

avoid offering inappropriate or excessive inducements when such inducements are likely to coerce participation.

### **5.5 Confidentiality of Research Data.**

Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

### **5.6 Publication.**

Marriage and family therapists do not fabricate research results. Marriage and family therapists disclose potential conflicts of interest and take authorship credit only for work they have performed or to which they have contributed. Publication credits accurately reflect the relative contributions of the individual involved.

### **5.7 Authorship of Student Work.**

Marriage and family therapists do not accept or require authorship credit for a publication based from student's research, unless the marriage and family therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on student research should be determined in accordance with principles of fairness and justice.

### **5.8 Plagiarism.**

Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

### **5.9 Accuracy in Publication.**

Marriage and family therapists who are authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the published materials are accurate and factual.

## **STANDARD VI**

### **TECHNOLOGY-ASSISTED PROFESSIONAL SERVICES**

*Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically-assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.*

#### **6.1 Technology Assisted Services.**

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their

communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

## **6.2 Consent to Treat or Supervise.**

Clients and supervisees, whether contracting for services as individuals, dyads, families, or groups, must be made aware of the risks and responsibilities associated with technology-assisted services. Therapists are to advise clients and supervisees in writing of these risks, and of both the therapist's and clients'/supervisees' responsibilities for minimizing such risks.

## **6.3 Confidentiality and Professional Responsibilities.**

It is the therapist's or supervisor's responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

## **6.4 Technology and Documentation.**

Therapists and supervisors are to ensure that all documentation containing identifying or otherwise sensitive information which is electronically stored and/or transferred is done using technology that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

## **6.5 Location of Services and Practice.**

Therapists and supervisors follow all applicable laws regarding location of practice and services, and do not use technologically-assisted means for practicing outside of their allowed jurisdictions.

## **6.6 Training and Use of Current Technology.**

Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services, and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees.

# **STANDARD VII**

## **PROFESSIONAL EVALUATIONS**

*Marriage and family therapists aspire to the highest of standards in providing testimony in various contexts within the legal system.*

### **7.1 Performance of Forensic Services.**

Marriage and family therapists may perform forensic services which may include interviews, consultations, evaluations, reports, and assessments both formal and informal, in keeping with applicable laws and competencies.

### **7.2 Testimony in Legal Proceedings**

Marriage and family therapists who provide expert or fact witness testimony in legal proceedings avoid misleading judgments, base conclusions and opinions on appropriate data, and avoid inaccuracies insofar as possible. When offering testimony, as marriage and family therapy experts, they shall strive to be accurate, objective, fair, and independent.

### **7.3 Competence.**

Marriage and family therapists demonstrate competence via education and experience in providing testimony in legal systems.

### **7.4 Informed Consent.**

Marriage and family therapists provide written notice and make reasonable efforts to obtain written consents of persons who are the subject(s) of evaluations and inform clients about the evaluation process, use of information and recommendations, financial arrangements, and the role of the therapist within the legal system.

### **7.5 Avoiding Conflicts.**

Clear distinctions are made between therapy and evaluations. Marriage and family therapists avoid conflict in roles in legal proceedings wherever possible and disclose potential conflicts. As therapy begins, marriage and family therapists clarify roles and the extent of confidentiality when legal systems are involved.

### **7.6 Avoiding Dual Roles.**

Marriage and family therapists avoid providing therapy to clients for whom the therapist has provided a forensic evaluation and avoid providing evaluations for those who are clients, unless otherwise mandated by legal systems.

### **7.7 Separation of Custody Evaluation from Therapy.**

Marriage and family therapists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist obtains appropriate consents to release information.

### **7.8 Professional Opinions.**

Marriage and family therapists who provide forensic evaluations avoid offering professional opinions about persons they have not directly interviewed. Marriage and family therapists declare the limits of their competencies and information.

### **7.9 Changes in Service.**

Clients are informed if changes in the role of provision of services of marriage and family therapy occur and/or are mandated by a legal system.

### **7.10 Familiarity with Rules.**

Marriage and family therapists who provide forensic evaluations are familiar with judicial and/or administrative rules prescribing their roles.

## STANDARD VIII

### FINANCIAL ARRANGEMENTS

*Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.*

#### **8.1 Financial Integrity.**

Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals. Fee-for-service arrangements are not prohibited.

#### **8.2 Disclosure of Financial Policies.**

Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

#### **8.3 Notice of Payment Recovery Procedures.**

Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

#### **8.4 Truthful Representation of Services.**

Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

#### **8.5 Bartering.**

Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.

#### **8.6 Withholding Records for Non-Payment.**

Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

## STANDARD IX

### ADVERTISING

*Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.*

### **9.1 Accurate Professional Representation.**

Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law.

### **9.2 Promotional Materials.**

Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law.

### **9.3 Professional Affiliations.**

Marriage and family therapists do not hold themselves out as being partners or associates of a firm if they are not.

### **9.4 Professional Identification.**

Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

### **9.5 Educational Credentials.**

Marriage and family therapists claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields.

### **9.6 Employee or Supervisee Qualifications.**

Marriage and family therapists make certain that the qualifications of their employees and supervisees are represented in a manner that is true, accurate, and in accordance with applicable law.

### **9.7 Specialization.**

Marriage and family therapists represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm.

### **9.8 Correction of Misinformation.**

Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

## **Download the AAMFT Code of Ethics PDF**

## **Legal and Ethics Consultations**

Your membership in AAMFT allows you access to various member benefits, including consultations with AAMFT's legal and ethics staff. All members of AAMFT are eligible to receive Ethical Advisory Opinions. Members in the following AAMFT membership categories are eligible for Legal Consultations: Pre-Allied Mental Health Professional Members, Allied Mental Professional Members, Pre-Clinical Fellow, and Clinical Fellow.

# Ethics Complaint Process

The AAMFT Ethics Committee has the ability to investigate complaints against AAMFT members for alleged violations of the AAMFT Code of Ethics.



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