UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

DAVID SCHWARTZ, Plaintiff, -v- THE CITY OF NEW YORK, and LORELEI SALAS, in her official capacity as Commissioner of the New York City Department of Consumer Affairs, Defendants.	Case No. 1:19 Civ. 00463 (RJD) (ST)

DECLARATION OF JUDITH M. GLASSGOLD IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

Judith M. Glassgold, Psy.D, a licensed psychologist, declares the truth of the following under penalty of perjury, pursuant to 28 U.S.C. § 1746:

1. I have been retained by counsel for Defendants as a consultant in connection with the above-referenced litigation. I have personal knowledge of the contents of this declaration, and if called upon to testify, I could and would testify competently to the contents of this declaration.

2. My background, experience, and scholarly publications are summarized in my curriculum vitae, which is attached as Exhibit A to this report.

3. I am a Lecturer and Clinical Supervisor at the Graduate School of Applied and Professional Psychology of Rutgers, the State University of New Jersey. I earned my Psy.D. in Clinical Psychology in 1989 from Rutgers, the State University of New Jersey. I have taught and supervised graduate students at Rutgers in psychology and psychotherapy, especially in the area

of sexual orientation and gender, as well as in the treatment of depression, anxiety, suicidality, and trauma.

4. I am a licensed psychologist in New Jersey. From 1991 to 2009, I maintained a clinical practice in New Jersey working with all ages on a broad range of psychological and mental health issues. I specialized in lesbian, gay, bisexual, and transgender (LGBT) issues working with children, adolescents, and adults. In that capacity, I worked with hundreds of individuals struggling with sexual orientation and gender identity and expression.

5. I have extensive experience in public policy, including on providing nonpartisan, expertise on health issues for Congress. In that capacity, I advised on health policy issues and provided policy consultations on sexual orientation, gender identity, and conversion therapy. I worked for the American Psychological Association as an Associate Executive Director in the Public Interest Directorate and developed public policies based on the science of psychology and represented the association to policy makers in Congress and federal agencies. One of the key areas I worked on were policies related to sexual orientation and gender identity. I am currently the Director of Professional Affairs at the New Jersey Psychological Association where I advise psychologists on clinical issues and the New Jersey Psychological Association on legal, regulatory and practice issues, including the New Jersey law banning conversion therapy.

6. In my writing and policy work, I focus on public policy, public health, psychology, and civil rights. I have authored a number of papers, presentations, and trainings related to the harmful effects of conversion therapy as well as appropriate approaches for those distressed by their sexual orientation or who face conflicts between their religious beliefs and sexual orientation. I have written extensively on these topics, as my curriculum vitae reflects,

including 20 professional articles, professional book chapters and books and presented over 60 trainings on psychotherapy of sexual orientation and gender identity.

7. I am member of the American Psychological Association (APA) and the New Jersey Psychological Association. I earned Fellow status of the American Psychological Association due to my expertise in sexual orientation and psychology of gender. I have received multiple professional honors and awards, including election to leadership positions in national associations, invitations to present at professional conferences, appointments to committees, the awarding of professional fellowships, and recognition of my scholarly achievement and public service.

8. My varied and successful professional experiences have allowed me to develop a broad expertise in sexual orientation, gender identity, professional ethics, and related topics.

9. I served as the Chair of the American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2007-2009) and co-wrote and edited the final report released in 2009 (the “APA Report”), attached as Exhibit B.[1] The APA Report was undertaken to answer fundamental questions about the benefits and harms of SOCE and was published with an accompanying Resolution to inform mental health providers, patients and their families, policy makers, community organizations, and faith-based organizations on the appropriate treatment for those distressed by their sexual orientation.

10. I served as one of the APA staff coordinators for the expert consensus panel that provided the basis of the final report of the 2015 US Substance Abuse and Mental Health Services Administration (SAMHSA) “Ending Conversion Therapy: Supporting and Affirming

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[1] Am. Psychl. Ass’n, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009).

LGBT Youth" (Exhibit C).[2] I also contributed to the writing and editing of the final report. This report rejects the use of SOCE and provides the scientific basis for beneficial and effective alternative treatments.

11. Since the publication of both of these reports, I have provided extensive training at conferences for educators, mental health, medical and social service professionals on sexual orientation change efforts, conversion therapy and appropriate interventions for children, adolescents, and adults addressing distress or conflicts regarding sexual orientation and gender identity. *See* Exhibit A.

12. In the past 10 years, I have provided consultation on state legislation regarding sexual orientation and conversion therapy, advised interested parties on the risks and benefits of psychological interventions, and provided legal expert testimony by declaration in matters such as *King v. Christie* (2014). I was qualified as an expert in psychology in connection with proceedings in New Jersey Family Court, where I provided expert testimony on multiple occasions during the early 1990s.

I. Background and Definitions

13. Sexual orientation is a well-established concept in psychology. Sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions and behaviors directed to another person. Sexual orientation is an objective, human phenomenon that can be assessed and measured. Sexual orientation is usually discussed in terms of four categories: heterosexual, lesbian, gay, and bisexual.

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[2] Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, HHS Publication No. (SMA) 15-4928 (2015).

14. Decades of scientific research has shown unequivocally that heterosexual, gay, lesbian, and bisexual sexual identities are part of the normal spectrum of human sexual orientation and are not a mental illness or developmental defect.

15. Gender identity is an established concept in psychology, referring to an internal, deeply-rooted sense of oneself as belonging to a particular gender; it is distinct from sexual orientation. Gender expression refers to how an individual expresses their internal sense of identity, including through their demeanor, dress, and behavior. Most people have a gender identity that is congruent with their assigned sex at birth. For a transgender person, however, their gender identity does not match their assigned sex at birth. In addition, many people are gender-nonconforming—that is, their gender expression does not conform to traditional gender role. Being gender nonconforming does not mean that a person is lesbian, gay, bisexual, or transgender. Gender identity is an objective, human phenomenon and can be assessed and measured.

16. Decades of scientific research has shown that variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder or developmental defect.

17. Conversion therapy, also called sexual orientation change efforts ("SOCE") or reparative therapy, refers to psychological interventions that seek to change the treatment recipient's sexual orientation from gay, lesbian, or bisexual to heterosexual, or to change a transgender gender identity or gender non-conforming identity to match the sex assigned at birth or reduce gender non-conforming behaviors and demeanor. Currently, SOCE is attempted primarily by talk therapies including role plays, behavior modification through non-aversive techniques, psychoanalytic techniques, cognitive therapies, medical approaches, family therapy,

and religious and spiritual efforts. SOCE can include non-aversive and aversive techniques, and is sometimes be engaged in by choice and sometimes imposed on the recipient.

18. SOCE aimed at changing sexual orientation and gender identity and expression is often based on the inaccurate and stereotyped notions that same-sex attractions and gender identity diversity are disordered and inferior to opposite-sex attractions and cisgender identification,[3] and that lesbian, bisexual, gay, and transgendered (LGBT) individuals are incapable of leading productive lives and engaging in stable sexual and family relationships. These assumptions are inconsistent with current psychological research and understanding of sexual orientation and gender identity.

19. Many psychotherapies are delivered though verbal interactions (talk, words, discussion, interpretation), though some are delivered through a combination of verbal discussion, emotional attachment, and actions, such as establishment of emotional safety and connection, activities such as play, neurological desensitization, rebutting of irrational beliefs and thoughts, and behavioral exposure and desensitization. Most often, therapy rebuts irrational and unscientific beliefs about oneself and others. Although therapies differ amongst themselves in the focus and the content of the verbal interactions, the focus of the verbal discussions are to deliver experiences that improve health.

II. Sexual Orientation Change Efforts Are Ineffective

20. The current practice in mental and behavioral healthcare emphasizes the delivery of empirically validated treatments where interventions are subject to careful evaluation to assess safety and effectiveness. These psychotherapies are treatments that have a valid scientific basis for their theoretical content and/or interventions. Not all approaches have equal validity;

[3] Cisgender means identifying with the gender that is the same as the biological sex identified at birth.

therapeutic claims and approaches are subject to empirical verification, which is a reason for their recognition as part of health care practice.

21. SOCE is rejected by mainstream mental health practitioners and professional association and guidelines because (1) it is unsupported by valid evidence of efficacy; and (2) significant valid evidence shows that it can pose harm to patients who receive it. *See infra* Part III. Research on SOCE does not have a valid scientific basis for its underlying theories or its interventions. The American Psychiatric Association has explicitly rejected the theoretical basis of SOCE due to significant evidence that sexual orientation and gender diversity are normal human variations. Exhibit D.[4] There is no valid scientific evidence verifying SOCE claims of change of sexual orientation or attractions. Rather, multiple reviews of the research literature, such as the APA Report, and empirical research, found that SOCE is ineffective and poses significant harms to individuals of all ages. *See* Exhibit B at 2-4; Exhibit E;[5] Exhibit F;[6] Exhibit G;[7] Exhibit H.[8] SOCE has been found to have no benefits and pose a risk of significant harm and thus cannot qualify as a valid mental health intervention. These points will be detailed in the following sections.

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[4] Am. Psychiatric Ass'n, Board of Trustees and Assembly, *Position Statement on Issues Related to Homosexuality* (2013).

[5] Dehlin, J. P. et al., *Sexual Orientation Change Efforts Among Current or Former LDS Church Members,* 62 Journal of Counseling Psychology 95 (2015).

[6] Kate Bradshaw et al., *Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated With the Church of Jesus Christ of Latter-day Saints*, 41:3 Journal of Sex & Marital Therapy 391 (2015).

[7] Flentje, A. et al., *Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification*, 61(9) Journal of Homosexuality 1242 (2014).

[8] Maccio, E.M., *Self-Reported Sexual Orientation and Identity Before and After Sexual Reorientation Therapy*, 15(3) Journal of Gay and Lesbian Psychotherapy 242 (2011).

22. All existing valid empirical research data show that SOCE is ineffective. There is no existing valid research that shows that sexual orientation can be changed by psychological interventions. In 2007, the APA formed a task force, which I chaired, to review the existing psychological evidence on SOCE and evaluate its benefits and harms. The resulting Report, "Appropriate Therapeutic Responses to Sexual Orientation," and the accompanying APA Resolution rejected SOCE as a valid treatment for patents. *See* Exhibit B; Exhibit I.[9] The conclusions of the Report have been confirmed by subsequent research. *See* Exhibits G, H, and I.

23. Claims of effectiveness made by SOCE providers and proponents have either been disproved by recent scientific research, failed to survive scientific scrutiny, or been retracted by their authors. SOCE claims of effectiveness are marred by serious methodological errors in research design and analysis, inappropriate claims of causality, or invalid generalizations from anecdotal claims based on single-case studies or select populations. The APA Task Force on SOCE found "serious methodological problems in this area of research," including that "only a few studies met the minimal standards for evaluating whether psychological treatments such as efforts to change sexual orientation are effective." *See* Exhibit B at 2.[10] Based on its review of the studies that met these standards, the APA Report reached the following conclusion:

> [E]nduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that

[9] Am. Psychl. Ass'n, *Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (2009), *reprinted in* Anton, B.S., *Proceedings of the American Psychological Association for the Legislative Year 2009: Minutes of the Annual Meeting of the Council of Representatives and Minutes of the Meetings of the Board of Directors*, American Psychologist 385 (2010).

[10] The common limitations cited by the APA include composition and recruitment of test subjects; attrition; inadequate assessments of sexual orientation; inadequate description of interventions and procedures; unclear definitions for evaluating success; and problems with timing of the assessments.

> could be empirically validated, though some showed lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE.

See Exhibit B at 2-3. This review of the literature included both aversive methodologies and non-aversive talk therapies, and included instances where the treatments in question had been sought by the recipient.

24. After the release of the Task Force report, the APA Council of Representatives passed a resolution that stated, in part, "the APA concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation" and "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." Exhibit I at 3.

25. There is limited research on SOCE that post-dates the APA's comprehensive review of psychological evidence through 2007, however all such research that is methodologically sound confirms the conclusions of the APA Task Force that SOCE is (1) ineffective and (2) harmful. No valid research conducted since 2007 supports the causal claim that individuals will be able to change their sexual orientation, eliminate same-sex sexual attractions and arousal, or achieve a heterosexual sexual orientation through SOCE.

26. Since 2007, three research teams have completed studies, using representative sample populations, that assessed participants' evaluations of their experiences with SOCE. These studies found that participants in SOCE do not report the elimination of same-sex arousal or sexual orientation change to heterosexual. *See* Exhibit E-H. This conclusion is all the more striking given that the studies assessed participants' self-reported, generally retrospective perceptions of their experiences, which were not independently measured or verified. These

types of studies cannot establish causal claims and often reflect positive client appraisals.[11] Many of these participants also reported significant harms.

27. One research group (Bradshaw, Dehlin, and colleagues) evaluated the experiences of 1600 members of the Church of the Latter Day Saints. One thousand sixty of the study's 1600 total participants reported going through SOCE, with 898 reporting that they had engaged in practices with a licensed mental health counselor. *See* Exhibits E-F. Only one individual of a subset of almost 1000 individuals who reported participating in SOCE perceived that their sexual orientation may have shifted significantly, and even this individual reported still experiencing same-sex attractions. Exhibit E at 6. The vast majority of participants of those who saw a licensed mental health provider reported that efforts were either ineffective or harmful. A few participants reported shifts in their perception of their sexual attractions, although these perceptions were not validated by independent measures, and reported coping strategies that accommodated their faith and same-sex orientation (e.g., reduction in sexual behavior or celibacy). One research participant in this group concluded "the feelings don't go away." Exhibit F at 408. The ineffective interventions received by participants in this study included both aversive therapies and non-aversive talk therapies, which were in some cases pursued by the participant.

III. Sexual Orientation Change Efforts Are Harmful To Patients

28. Evidence shows that SOCE interventions pose the risk of significant harm to participants.[12] Past studies described in the 2009 APA Report indicate that the risks of harm include reported feelings of distress, anxiety, depression, suicidal ideation, increase in substance

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[11] See discussion of research adequacy in APA Report, chapter 3. Exhibit B at 26.

[12] The Task Force report provides a detailed discussion of this topic and an extensive review of relevant research published prior to 2007. *See* Exhibit B at 35-43.

abuse, self-blame, guilt, and loss of hope among other negative feelings, as well as disillusionment with religious faith, and harm to family relationships. Research published recently reported that 37% reported moderate and significant harms including those found in the APA Report, such increased risk of suicidality, depression, self-blame, and disillusionment with faith. Exhibit F at 408; *see also* Exhibit G at 1257.

29. Both aversive and non-aversive talk forms of SOCE pose a significant risk of harms; this includes even talk therapies pursued by the recipient. For example, research reviewed in the APA Report included evaluations of talk therapies pursued by the recipient, in which outcomes were not guaranteed. The APA report found that participants in talk therapies and religious efforts reported: (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. The risk of harm is particularly significant for those patients who fail to change their sexual orientation when they expect to be able to change. These patients are at risk for increased shame, guilt, depression, issues with intimacy, sexual dysfunction, and suicidality. *See* Exhibit J;[13] Exhibit K;[14] Exhibit F at 407. Further, Bradshaw, Dehlin and colleagues (2015) reported harms from both aversive and non-aversive treatments as well as voluntary, talk therapies. Exhibit F at 398, 407. The research conducted by Dehlin, Gallagher,

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[13] Douglas Haldeman, *Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies* (2001).

[14] Michael Schroeder et al., *Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers*, 5:3-4 Journal of Gay & Lesbian Psychotherapy 131 (2002).

et al. and Bradshaw, Dehlin and colleagues found similar mental health and emotional distress were reported by participants. Exhibit E at 7-8; Exhibit F at 398, 407-08.

30. Evaluations of SOCE since 2007 have focused almost exclusively on talk therapies and religious efforts. These studies on LDS SOCE participants found that 37% of participants in SOCE perceived they have experienced moderate or severe harm by these efforts. Exhibit F at 408. Valid psychotherapeutic practices do not harm patients. Clinicians expect that on occasion a patient may not respond to psychotherapy (i.e. their symptoms may not improve notwithstanding the appropriate use of valid therapies), however, it is not accepted in the clinical practice of psychology to use interventions that are reported to cause harm in a substantial portion of patients that receive them. The harms of SOCE resulted from ineffective treatment of mental health conditions as well as the harmful impact of treatment based on inaccurate and stereotyped information regarding sexual orientation and gender identity that increased distress.

31. Pursuing SOCE can prevent or delay other treatments that may be beneficial to patients that could lead to symptom reduction. That is, during the time a patient is undergoing SOCE, he or she is forgoing the opportunity to seek treatment from providers offering legitimate psychotherapy supported by in empirical evidence of efficacy. Thus, providing SOCE can potentially worsen mental health symptoms including depression, suicidal ideation, and substance abuse.

32. In contrast, participants in this recent research reported benefits when they received therapy that allowed them to explore their own sexual orientation without a pre-determined outcome and who received prompt mental health treatment for distress. Exhibit F at 398. This confirms the findings of the 2009 APA Report.

33. SOCE's ineffectiveness and potential risk for harm is settled science. SOCE is

rejected as a treatment by all the major mental health, counseling and health organizations in the United States, as well as many international health associations and government entities. SOCE is rejected by the American Psychological Association, American Psychiatric Association, American Medical Association, American Academy of Family Physicians, American Academy of Child and Adolescent Psychiatry, American Counseling Association, American Association of Pediatrics, American Psychoanalytic Association, Australian Psychological Society, British Psychological Association, Endocrine Society, National Association of Social Workers, Psychological Society of Ireland, Psychological Society of South Africa, and the World Professional Association for Transgender Health. *See* Exhibit I; Exhibit D; Exhibit L;[15] Exhibit M;[16] Exhibit N;[17] Exhibit O;[18] Exhibit P;[19] Exhibit Q;[20] Exhibit R;[21] Exhibit S;[22] Exhibit T;[23]

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15 Am. Med. Ass'n, *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations* (2018).

16 Am. Acad. of Family Physicians, *Reparative Therapy* (2016).

17 Am. Acad. of Child & Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. Am. Acad. Child & Adolescent Psychiatry 957 (2012).

18 Joy S. Whitman *et al.*, Am. Counseling Ass'n, *Ethical Issues Related to Conversion or Reparative Therapy* (2013).

19 Am. Ass'n of Pediatrics, *Homosexuality and Adolescence*, 92 Pediatrics 631 (1993).

20 Am. Psychoanalytical Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012).

21 Austl. Psychological Soc'y, *APS Position Statement on Psychological Practices that Attempt to Change Sexual Orientation* (2015).

22 British Psychological Soc'y *et al.*, *Memorandum of Understanding on Conversion Therapy in the UK* (2017).

23 Wylie C. Hembree *et al.*, *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clinical Endocrinology & Metabolism 3132 (2009).

Exhibit U;[24] Exhibit V;[25] Exhibit W;[26] Exhibit X.[27]

34. The American Psychiatric Association reiterated its opposition to SOCE in November 2018, *see* Exhibit Y,[28] and re-endorsed the dangers associated with SOCE in its position statement of 2013:

> The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed.

Exhibit D.

35. The American Psychiatric Association Board of Trustees has also rejected the validity of the developmental theories underpinning SOCE, noting the absence of any rigorous scientific evidence supporting these approaches, and recommending that practitioners refrain from attempts to change individuals' sexual orientation. *See* Exhibit Z.[29]

36. SOCE is not only an inappropriate treatment for sexual orientation issues, but also not a scientifically valid treatment for sexual conflicts, sexual abuse or sexually compulsive (out of control or "addictive" sexual behaviors). Scientifically valid treatments for these conditions do not include efforts based on SOCE or changing sexual attractions, orientation and gender

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[24] Nat'l Ass'n of Soc. Workers, *Position Statement: Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons* (2015).

[25] Irish Council for Psychotherapy, *Position on Conversion Therapy, Reparative Therapy, Gay Cure and Transgender Conversion Therapy in Ireland* (2017).

[26] Psychological Soc'y of S. Africa, *Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People* (2017).

[27] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (2012).

[28] Am. Psychiatric Ass'n, *APA Reiterates Strong Opposition to Conversion Therapy* (Nov. 15, 2018).

[29] Am. Psychiatric Ass'n, *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): COPP Position Statement* (2000).

identity. In these cases, SOCE poses a significant risk to mental health by reinforcing damaging stereotypes and increasing shame related to sexuality.

IV. Appropriate Treatment For Those Distressed By Conflicts Surrounding Sexual Orientation

37. A prohibition on SOCE does not limit health professionals from providing competent care to those who are distressed by their sexual orientation or gender identity. There are both well-accepted therapeutic techniques as well as specialized approaches that help to resolve conflicts and distress, including conflicts between religion, on the one hand, and sexual orientation and gender identity, on the other. SOCE is not among these accepted approaches.

38. Decades of studies, including recent randomly-controlled evaluations of therapy, indicate that patients benefited from therapies that provide accurate information about sexual orientation and gender identity. Approaches that reduce the stigma, fear, and shame surrounding sexual orientation and gender diversity are effective at reducing mental health symptoms. *See, e.g.*, Exhibit AA.[30] These treatments are based on a significant body of research that indicate that anti-LGBT stigma, and the stress of anti-LGBT prejudice and discrimination (often termed "minority stress") can trigger chronic feelings of shame and/or guilt. Past and current exposure to negative social stereotypes; rejection or lack of support in family relationships, and discrimination at school, community organizations and work can trigger mental health symptoms and unhealthy coping behaviors.

39. The APA Report and subsequent research examined the issue of the appropriate treatment for those who are distressed by conflicts between religious beliefs and sexual orientation, many of whom appear to participate in SOCE. These patients appear to come from

[30] Pachankis, J. E., et al., *LGB- Affirmative Cognitive-Behavioral Therapy for Young Adult Gay and Bisexual Men: A Randomized Controlled Trial of a Transdiagnostic Minority Stress Approach*, 83(5) Journal of Consulting and Clinical Psychology 875, 886 (2015).

faiths that believe heterosexuality and other-sex relationships are perceived as part of the natural order and are morally superior to homosexuality. Research on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid. Such individuals feel tremendous isolation and loneliness due to the perceived rejection of their same-sex attractions by their faith. Many such individuals have limited access to accurate psychological research on LGBT lives.

40. These individuals are extremely vulnerable to claims of SOCE as they believe change is required by their faith and may keep trying to change their sexual orientation despite risks to their mental health. Most of these individuals participated in different forms of SOCE over the course of several years increasing the risk of harm due to lack of appropriate treatment as well as harmful interventions. There are unique risks of harms in such cases, such as disillusionment with faith and lack of effective treatment of chronic mental health disorders.

41. Based on this research and the unique risks of certain groups, the APA Report endorsed the position that enduring change in sexual orientation is unlikely from SOCE and that patients perceive a benefit when offered affirmative approaches that support, accept, and recognize important values, including religious concerns.

42. This APA Report recommendation is supported by the work of Bradshaw, Dehlin and colleagues (2015) showing that participants perceived efforts to be most helpful when they worked with a counselor to clarify their own values and goals without having a pre-set goal of sexual orientation change or acceptance. Exhibit F at 398.

43. There are numerous examples of research-based approaches for those with conflicts between faith and sexual orientation and gender identity. *See* Exhibit BB;[31] Exhibit CC.[32] Specifically, the APA Report recommended the appropriate application of therapeutic interventions for all adults who are distressed by their sexual orientation that have the following central elements: (a) acceptance and support, (b) a comprehensive assessment (including mental health concerns), (c) active coping, (d) social support, and (e) identity exploration and development without a pre-determined outcome. These interventions are helpful for those from all backgrounds, including conservative religious faiths. These well-accepted psychotherapy treatments provide these benefits without the risks of SOCE.

V. Gender Identity Change Efforts

44. SOCE often includes efforts to ensure that gender expression (actions and dress associated with gender roles) conform to traditional gender roles as well as that gender identity is consistent with the sex assigned at birth. These efforts are sometimes termed gender identity change efforts ("GICE").

45. GICE is fundamentally inconsistent with the consensus view of the medical, psychiatric, and psychological communities regarding the appropriate care of gender diverse and transgender individuals, and it poses a risk of significant harm.

46. The World Professional Association for Transgender Health (WPATH) promulgated Standards of Care (SOC) that are the internationally recognized guidelines and inform psychological and medical treatment throughout the world. *See* Exhibit X.[33] The

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[31] Levy, D.L. & Reeves, P., *Resolving identity conflict: Gay, Lesbian, and Queer Individuals with a Christian upbringing*, 23(1) Journal of Gay & Lesbian Social Services 53 (2011).

[32] Sherry, A., et al., *Competing Selves: Negotiating the Intersection of Spiritual and Sexual Identities*, 2 Professional Psychology: Research and Practice 112 (2010).

[33] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (2012).

WPATH SOC are formulated and revised over a period of nearly 30 years by the foremost experts in the care of transgender and gender diverse individuals, informed by the available clinical data. The American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, and the American College of Obstetrics and Gynecology, among others, all endorse protocols in accordance with the WPATH SOC. *See* Exhibit T; Exhibit DD;[34] Exhibit EE;[35] Exhibit FF;[36] Exhibit GG;[37] Exhibit HH;[38] Exhibit II;[39] Exhibit JJ;[40] Exhibit KK.[41] The WPATH SOC affirm gender diversity and call for practitioners treating those who experience distress related to their gender identity to practice a "gender affirming" approaches, meaning treatments facilitating the alignment of the individual's physical body, gender expression, and social identity (i.e., demeanor, dress) with their gender identity.

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[34] Am. Med. Ass'n, *Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients* (2008).

[35] Am. Psychological Ass'n, *Transgender, Gender Identity, & Gender Expression Non-Discrimination* (2008).

[36] Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832 (2015).

[37] Am. Psychiatric Ass'n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012).

[38] Madeline B. Deutsch *et al.*, Am. Acad. of Family Physicians, *Updated Recommendations from the World Professional Association for Transgender Health Standards of Care*, 87 Am. Family Physician 92 (2013).

[39] Emilia Lombardi, *Enhancing Transgender Health Care*, 91 Am. J. Pub. Health 869 (2001).

[40] *LGBT Practice Tools*, Nat'l Ass'n of Soc. Workers (last viewed Mar. 28, 2019).

[41] Am. College of Obstetricians and Gynecologists, Committee on Health Care for Underserved women, *Committee Opinion Number 512: Health Care for Transgender Individuals* (December 2011, reaffirmed 2019).

47. The harms caused by GICE included increase in suicidal ideation and attempts, self-mutilation, increased depression and anxiety, increased self-hatred, hopelessness, shame and an increase in substance abuse and high-risk sexual behaviors. *See* Exhibit KK; Exhibit LL.[42]

VI. Conclusion

48. Interventions aimed at changing an individual's sexual orientation and gender identity have not been empirically demonstrated to be effective or safe. SOCE and GICE are ineffective no matter the demographics of the participants (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, ability status, language, and socioeconomic status).

49. SOCE and GICE pose significant risk of harm whether they are aversive or non-aversive, are coerced or requested by the participant, or employ talk therapy methods or active interventions. SOCE and GICE are harmful no matter the demographics of the participants (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, ability status, language, and socioeconomic status).

50. Practitioners are entitled to their personal beliefs. But they should not be permitted to provide discredited and harmful services to patients, especially those in extreme distress due to distressing conflicts between sexual orientation, gender identity and faith beliefs, to an unacceptable risk of severe and life-long harm, including significantly increased risks of anxiety, depression, suicidality, and substance abuse. Doing so is unconscionable and unethical.

51. The major mental health professional organizations stand uniformly opposed to SOCE and GICE and instead recommend affirmative approaches that address the stigma surrounding same-sex orientation and gender diversity and emphasize acceptance, support, and

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[42] Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, Journal of Homosexuality (2018).

recognition of important values, including religious faith. Alternatives that provide benefits without the risk of harm are available for all populations that are distressed.

52. These approaches are based on the scientific evidence that sexual orientation and gender identity diversity are normal and positive variants of human sexuality and are not indicators of mental or developmental disorders. Further, gay men, lesbians, bisexual, and transgender individuals can and do live satisfying lives and form stable, committed relationships and families; and no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation and gender diversity to family dysfunction or trauma.

Dated: March 28, 2019
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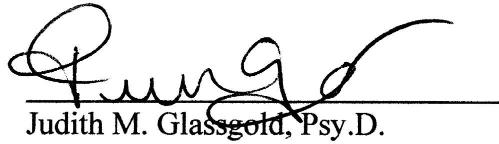

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