No. 19-10604

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

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

v.

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

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

BRIEF OF AMICI CURIAE EQUALITY FLORIDA INSTITUTE INC., NATIONAL CENTER FOR LESBIAN RIGHTS AND SOUTHERN POVERTY LAW CENTER IN SUPPORT OF DEFENDANTS-APPELLEES

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rules 26.1-1 through 26.1-3, amici curiae hereby certify that the following persons have an interest in the outcome of this appeal:

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No publicly traded corporation has an interest in the outcome of the case or appeal.

Dated: June 17, 2019

/s/ Sylvia H. Walbolt
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INTEREST OF AMICI CURIAE[1]

Equality Florida Institute, Inc., is the largest civil rights organization in the State of Florida that advocates on behalf of Florida's lesbian, gay, bisexual, transgender, and questioning (LGBTQ) residents. As part of Equality Florida's mission of combatting harassment and discrimination against LGBTQ Floridians, Equality Florida has supported the enactment of LGBTQ civil rights laws at the state, county, and municipal levels. Its 302,000 members include some of the very Boca Raton and Palm Beach County residents who are most in need of the protections the Ordinances at issue in this case provides, including LGBTQ children at risk of being subjected to conversion therapy.

The National Center for Lesbian Rights ("NCLR") is a national non-profit legal organization dedicated to protecting and advancing the civil rights of lesbian, gay, bisexual, and transgender people and their families through litigation, public policy advocacy, and public education. Since its founding in 1977, NCLR has played a leading role in securing fair and equal treatment for LGBT people and their families in cases across the country involving statutory, constitutional, and civil rights.

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[1] Counsel for the parties have not authored this brief in whole or in part. The parties and counsel for the parties have not contributed money that was intended to fund preparing or submitting the brief. No person other than the amici curiae contributed money that was intended to fund preparing or submitting the brief.

In particular, NCLR has supported the enactment of narrowly tailored laws and regulations that protect minors from the practice of conversion therapy by licensed therapists. NCLR represented intervenor parties and amici curiae in Third and Ninth Circuit cases that have upheld these laws against constitutional challenges. *See Pickup v. Brown,* 740 F.3d 1208 (9th Cir. 2014), *cert. denied,* 573 U.S. 945 (2014), *and cert. denied sub nom. Pickup v. Newsom,* No. 18-1244, 2019 WL 1331490 (U.S. May 20, 2019); *Welch v. Brown,* 834 F.3d 1041 (9th Cir. 2016), *cert. denied,* 137 S. Ct. 2093 (2017); *King v. Governor, State of New Jersey*, 767 F.3d 216 (3d Cir. 2014), *cert. denied sub nom. King v. Christie,* 135 S. Ct. 2048 (2015), *and cert. denied sub nom. King v. Murphy,* 139 S. Ct. 1567 (2019); *Doe v. Governor, State of New Jersey,* 783 F.3d 150 (3d Cir. 2015), *cert. denied* sub nom. *Doe v. Christie*, 136 S. Ct. 1155 (2016).

Southern Poverty Law Center ("SPLC") is a non-profit civil rights organization dedicated to fighting hate and bigotry, and to seeking justice for the most vulnerable members of society. Since its founding in 1971, the SPLC has won numerous landmark legal victories on behalf of the exploited, the powerless, and the forgotten. SPLC was counsel in *Ferguson, et al. v. JONAH, et al.*, No. L-5473-12 (N.J. Super. Ct. 2015) (permanently enjoining the marketing, sale, and provision of conversion therapy after unanimous jury verdict that conversion

therapy constitutes an unconscionable commercial practice and is a violation of the New Jersey Consumer Fraud Act).

INTRODUCTION

Amici curiae are in full agreement with the arguments set forth in the City's and County's briefs. As the City and County correctly explain, *National Institute of Family and Life Advocates ("NIFLA") v. Becerra*, 138 S. Ct. 2361, 2373 (2018) establishes that the government may, consistent with the First Amendment's Free Speech Clause, protect patients from harm by regulating particular medical treatments provided by licensed health care practitioners, even when doing so restricts some speech that is "part of the practice of medicine." 138 S. Ct. at 2373 (quoting *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992)).

The regulation of the medically discredited mental health treatments at issue in this case does not violate the First Amendment; instead, it properly protects the safety and well-being of minors from an unethical and dangerous treatment by licensed therapists—a treatment that is aimed at one single predetermined outcome as the only acceptable outcome for the child, even though the mental health community has concluded that outcome likely cannot be achieved.

Amici submit this brief to emphasize an additional point: even if the Ordinances are subjected to intermediate or strict scrutiny, they would survive First

Amendment review because they are narrowly tailored to advance the City's and County's compelling interest in protecting minors from the well-documented dangers of conversion therapy.

The challenged regulation is based on the consensus of the nation's leading medical and mental health organizations that this therapeutic treatment, having the sole, avowed goal of *changing* a young person's sexual orientation or gender identity, is ineffective, unethical, and unsafe. As numerous medical and mental health professional organizations have concluded, conversion therapy—regardless of whether it is performed using aversive or non-aversive techniques, and regardless of whether it occurs exclusively through talk therapy or through other methods—poses a risk of severe harm, placing already vulnerable youth at great risk of depression, suicidality, and other negative mental health outcomes.

The Ordinances are limited to this specific form of treatment for minors. They do not preclude this therapy for adults. Nor do they in any way restrict the expression of opinions about conversion therapy or any other subject, even within the relationship between therapists and minor clients.

The alternative regulations proposed by the Plaintiffs—restricting only "aversive" or "involuntary" treatments—would leave minors exposed to the very physical and emotional harms the Ordinances seek to prevent. Conversion therapy

is dangerous because it has a fixed goal of gender conformity or heterosexual orientation as the only acceptable result of treatment.

It is that predetermined outcome of therapy—one that mental health organizations have found likely cannot be achieved—that creates the danger to minors, not just the means by which the therapy is conducted. For similar reasons, mental health organizations likewise have determined this therapy to be inherently "coercive" for minors.

Because the therapy is aimed at a fixed and unattainable goal, there is no less restrictive way to protect minors from those serious harms. This Court should affirm the District Court's thorough and soundly-reasoned decision.

ARGUMENT

I. THE ORDINANCES ARE NARROWLY TAILORED TO ACHIEVE THE GOVERNMENT'S COMPELLING INTEREST OF PROTECTING MINORS FROM THE SERIOUS DANGERS OF CONVERSION THERAPY.

The City and County enacted the Ordinances to carry out their "compelling interest in protecting the physical and psychological well-being of minors." Doc. 126-20 - Pg. 10; Doc. 126-27 – Pg. 5. Governments have a compelling interest in the health and well-being of their citizens. *See Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975); *Watson v. Md.*, 218 U.S. 173, 176 (1910).

This government interest is especially compelling when a law or regulation aims to protect the health and well-being of minors. "A democratic society rests,

for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Mass.*, 321 U.S. 158, 168 (1944). Consequently, the Supreme Court "ha[s] sustained legislation aimed at protecting the physical and emotional well-being of youth even when the laws have operated in the sensitive area of constitutionality protected rights." *N.Y. v. Ferber*, 458 U.S. 747, 757 (1982).

This Court, too, has recognized that protecting the safety of children is an overriding governmental interest even when other constitutional values are at stake. *See Friedenberg v. Sch. Bd. of Palm Beach Cty.*, 911 F.3d 1084, 1107 (11th Cir. 2018) (state's compelling interest in protecting children outweighs intrusion on privacy interests of suspicionless drug testing for substitute teachers); *LaPlante v. Crosby*, 133 F. App'x 723, 726 (11th Cir. 2005) (recognizing the protection of "the physical and psychological well-being of a minor" as a "compelling" state interest in the context of a courtroom closure for minor-victim testimony); *Am. Booksellers v. Webb*, 919 F.2d 1493, 1501 (11th Cir. 1990) (upholding statute making it a criminal offense to display, in a place accessible to minors, any material deemed "harmful to minors" under the statute).

The governmental interest in protecting the health and well-being of children is unquestionably served here, where the government seeks to protect minors who are "especially vulnerable" to the mental health treatments barred by the

Ordinances. *King*, 767 F.3d at 238. The Ordinances rest on an overwhelming professional consensus that conversion therapy can seriously impair the psychological and physical well-being of minors.

Thus, the detailed legislative findings expressly summarize relevant research and the conclusions of well-known, reputable professional and scientific organizations that conversion therapy for minors is highly correlated with depression, suicidality, and other serious harms. *See* Doc. 126-20 - Pp. 8-11; Doc. 126-27 – Pp. 1-5.

This consensus applies to non-aversive therapy as well as aversive techniques, as it is the fixed goal of change as the only acceptable result of the therapy that is so dangerous for minors, who feel a sense of failure and lack of worth if they cannot effect a change of their sexual orientation or gender identity as they are being told by the therapist that they could do. Therapy designed to achieve that goal is condemned by all responsible medical organizations.

Plaintiffs assert that the research establishing the harms of conversion therapy is not absolutely conclusive. But the medical consensus that such treatment should not be provided to minors is broad and consistent, and research continues to establish the ineffectiveness and dangers of this therapy for minors. Indeed, new peer-reviewed research examining the impact of conversion therapy on minors found an astonishing rate of increased suicidality and depression among LGBT

youth subjected to this treatment: *more than sixty percent of youth subjected to conversion therapy attempted suicide*.

As the District Court noted, responsible professionals stopped conducting double-blind studies on conversion therapy precisely because it was harmful, and therefore would be unethical to attempt for minors. *See* Doc. 141 – Pg. 37 n.12; Doc. 126-22 – Pp. 24, 42, 67-68, 83. The First Amendment does not require the government to delay action to protect children from serious threats of harm until it possesses absolutely conclusive scientific proof, particularly when acquiring such proof risks producing the very harm the government seeks to avoid. *See FCC v. Fox Television Stations*, 556 U.S. 502, 519 (2009).

A. The Ordinances Are Narrowly Tailored Because They Only Prohibit A Specific Therapeutic Treatment That The Scientific Consensus Has Concluded Place Minors At Risk Of Harm Because Of Its Predetermined Goal Of Change.

The Ordinances are narrowly written to address only the specific therapeutic treatment that the medical and mental health professions have concluded provides no benefit and instead places youth at risk of serious harm because it is an "[i]ntervention[] aimed at a fixed outcome," Doc. 85-12 – Pg. 9, and a treatment "seeking predetermined outcomes," Doc. 126-22 - Pg. 88.

Thus, the only conduct that is prohibited for licensed mental health professionals is "the practice of seeking to change an individual's sexual orientation or gender identity," Doc. 126-20 – Pg. 12, or "any counseling, practice

or treatment performed with the goal of changing an individual's sexual orientation or gender identity," Doc. 126-27 – Pg. 6, and only with patients under 18 years of age.

Indeed, the Ordinances expressly disclaim any restriction of speech by mental health professionals that is not specifically part of providing conversion therapy. The ordinances "do[] not intend to prevent mental health providers from speaking to the public about [conversion therapy]; expressing their views to patients; recommending [conversion therapy] to patients; administering [it] to any person who is 18 years of age or older; or referring minors to unlicensed counselors, such as religious leaders." Doc. 126-20 – Pg. 10; *see also* Doc. 126-27 – Pg. 4.

Because they target only a specific form of mental health treatment that the medical consensus has found to be unsafe for minors, the Ordinances "restrict as little speech as possible to serve the goal" of protecting youth from harm. *Turner Broad. Sys., Inc. v. F.C.C.*, 512 U.S. 622, 680 (1994). As the Ninth Circuit observed in upholding a substantially similar California statute, the Ordinances "regulate[] the provision of mental treatment, but leave[] mental health providers free to discuss or recommend treatment and to express their views on any topic." *Pickup v. Brown*, 740 F.3d 1208, 1223 (9th Cir. 2014).

The District Court correctly observed that "[t]he speech of medical providers is routinely limited through prescription drug laws, medical malpractice lawsuits, accreditation requirements, and other means." *Id.* Compared to those laws, the Ordinances are even narrower. They apply only to conversion therapy of minors itself, rather than to discussions, recommendations, or referrals regarding conversion therapy with clients. They do not affect or limit any speech that is not part of that specific harmful treatment, and instead are narrowly tailored to accomplish their entirely proper objective: the protection of the physical and mental health of youth in the City and County.

B. The Medical Consensus That Both "Aversive" and Non-Aversive Conversion Therapy Places Minors At Risk Of Serious Harm Is Supported By Substantial Evidence.

1. Leading professional medical and mental health associations uniformly have warned that conversion therapy for minors is unsafe.

Although Plaintiffs challenge an early report of the American Psychological Association as supposedly being inconclusive, they ignore that *all* of our nation's leading medical and mental health associations have warned that conversion therapy for minors is dangerous to their health and well-being. According to the American Medical Association (AMA), subjecting minors to conversion therapy "violate[s] many important ethical principles, the foremost of which: 'First, do no harm.'" American Medical Association, *Issue Brief: LGBT Change Efforts*

("Conversion Therapy") (2019), https://www.ama-assn.org/system/files/2019-03/transgender-conversion-issue-brief.pdf, at 2.

More specifically, "[i]t is clinically and ethically inappropriate for health care providers to direct mental or behavioral health interventions, including SOCE [Sexual Orientation Change Efforts] and GICE [Gender Identity Change Efforts], *with a prescriptive goal aimed at achieving a fixed developmental outcome of a child's or adolescent's sexual orientation, gender identity or gender expression*." *Id*. at 3 (emphasis added).

The AMA specifically warns that conversion therapy may put LGBT youth at an increased risk of suicidality:

> SOCE may also increase suicidal behaviors in a population where suicide is prevalent. In young adults between 15 and 24 years old, suicide has been the second leading cause of death since 2011, and LGBTQ young adults are more than twice as likely to report a history of suicide attempts in comparison to their heterosexual peers. . . . Young LGBTQ adults who report higher levels of parental and caregiver rejection are 8.4 times more likely to report having attempted suicide.

Id. at 2 (internal citations omitted).

By definition, this treatment by licensed therapists constitutes a stark rejection of the minor's sexual orientation or gender identity, because its starting premise is that change is the only acceptable outcome. As well, minors often are subjected to it by parents who disapprove of their sexual orientation or gender

identity. When change cannot be achieved by the therapy, however, serious damage is done to these vulnerable minors.

Thus, the American Academy of Pediatrics has stated: "Referral for 'conversion' or 'reparative therapy' is *never indicated*; therapy is not effective and may be harmful to LGBTQ individuals by increasing internalized stigma, distress, and depression."[2]

The American Academy of Child & Adolescent Psychiatry (AACAP) similarly has warned that "'conversion therapies' (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful."[3] It concludes that "'conversion therapies' should not be part of any behavioral health treatment of children and adolescents."

Many other medical and mental health organizations have issued similar statements unequivocally rejecting conversion therapy as unsafe for minors. These include, among others:

The American Psychiatric Association

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[2] https://pediatrics.aappublications.org/content/132/1/198.full?sid=baab3d90-dd2d-4618-8b7d-b3091d6eb732 (emphasis added).
[3] https://www.aacap.org/aacap/policy_statements/2018/Conversion_Therapy.aspx

The American College of Physicians

The American Association for Marriage and Family Therapy

The National Association of Social Workers

The American Psychoanalytic Association

The American Counseling Association

The American School Counselor Association

The American School Health Association

The American Academy of Nursing

The American Osteopathic Association

The Pan American Health Organization

The World Psychiatric Association[4]

2. **The American Psychological Association has concluded that therapists should not engage in conversion therapy with minors.**

In 2009, the American Psychological Association (APA) analyzed clinical, ethical, and scientific issues relating to conversion therapy in a report entitled "Appropriate Therapeutic Responses to Sexual Orientation." Doc 126-22. It found that "efforts to change sexual orientation are unlikely to be successful and involve

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[4] See Doc. 126-20 – Pp. 8-10 (collecting statements); Doc. 126-27 – Pp. 1-4 (same); American Medical Association, *Issue Brief: LGBT Change Efforts ("Conversion Therapy")* (2019), https://www.ama-assn.org/system/files/2019-03/transgender-conversion-issue-brief.pdf, at 3 (same).

some risk of harm, contrary to the claims of SOCE practitioners and advocates." Doc. 126-22 – Pg. 7 (APA Report at *v*). With respect to minors in particular, the APA "found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation." Doc. 126-22 – Pg. 87 (APA Report at 79). And yet conversion therapy has as its only acceptable and inflexible outcome exactly that change.

The APA concluded that licensed mental health providers should not engage in sexual orientation change efforts with minors under any circumstances, regardless of whether the techniques used are aversive or non-aversive. *See id.* – Pg. 88. Indeed, the APA specifically emphasized that licensed mental health providers should not engage in conversion therapy even with "children and adolescents who present a desire to change their sexual orientation or behavioral expression of their sexual orientation or both, or whose guardian expresses a desire for the minor to change." *Id.* - Pp. 87-88.

Instead, therapists should provide "competent and client-centered therapies to children, adolescents, and their families *rather than [conversion therapy]* . . . . These approaches would support children and youth in identity exploration and development *without seeking predetermined outcomes*." *Id.* - Pg. 88 (emphases added).

Since 2009, the APA has reiterated that subjecting minors to conversion therapy is dangerous and ineffective:

- "Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression or sexual orientation, should not be part of behavioral health treatments." American Psychological Association, *APA Applauds SAMSHA Report Calling for End to Conversion Therapy for Youth*, (Oct. 15, 2015), https://www.apa.org/news/press/releases/2015/10/conversion-therapy

- "So-called reparative therapies are aimed at 'fixing' something that is not a mental illness and therefore does not require therapy. There is insufficient scientific evidence that they work, and they have the potential to harm the client." American Psychological Association, *American Psychological Association Applauds President Obama's Call to End Use of Therapies Intended to Change Sexual Orientation* (Apr. 9, 2015), https://www.apa.org/news/press/releases/2015/04/therapies-sexual-orientation

3. **In 2015, the Substance Abuse and Mental Health Services Administration found that therapeutic treatments aimed at changing a minor's sexual orientation or gender identity "are coercive, can be harmful, and should not be part of behavioral health treatment."**

Subsequent research has confirmed and strengthened the APA's conclusions. In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services conducted an updated survey of existing research on conversion therapy, with a specific focus on minors. *See* Doc. 85-12 – Pg. 9 (Substance Abuse and Mental Health Serv. Admin., U.S. Dep't of Health and Human Serv., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Oct. 2015), at 1).

The agency found that "[i]nterventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment." *Id*. It concluded that mental health approaches for youth should be guided by "the goal of treatment being the best possible level of psychological functioning, *rather than any specific gender identity, gender expression, or sexual orientation.*" Doc. 85-12 - Pg. 11.

The American Psychological Association subsequently endorsed these findings and called for an end to conversion therapy on minors: "This important report makes it clear that conversion therapy is not appropriate for dealing with sexual orientation or gender identities in children and youth." American Psychological Association, *APA Applauds SAMSHA Report Calling for End to Conversion Therapy for Youth*, (Oct. 15, 2015), https://www.apa.org/news/press/releases/2015/10/conversion-therapy.

4. Recent research has found that sixty-five percent of adolescents subjected to conversion therapy attempted suicide.

In 2018, a peer-reviewed study found that more than sixty percent of young adults who had been subjected to conversion therapy as adolescents had attempted suicide. *See* Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts with LGB Adolescents: Implications for Young Adult Mental Health and Adjustment*, Journal of Homosexuality (2018), at 9 (attached hereto as Addendum).

Youth who had been subjected to conversion therapy experienced significantly worse outcomes than youth who had not. *Id*. at 8-10.

In particular, LGBT youth "who experienced [conversion therapy] were more likely to have suicidal thoughts . . . and to report suicidal attempts and higher levels of depression." *Id*. at 8. LGBT youth who were subjected to conversion therapy were nearly three times more likely to attempt suicide, and more than three times as likely to experience serious depression, than LGBT youth who were not subjected to conversion therapy. *Id*. at 10 (Table 3). After being subjected to SOCE, sixty-five percent—more than 6 out of 10—attempted suicide. *Id*.

This research is directly relevant to the constitutionality of the Ordinances. It studied the very treatment the Ordinances prevents and found that this treatment puts LGBT youth at a dramatically heightened risk of depression and suicidality—plainly dangers that governments have a compelling interest in preventing.

In light of this overwhelming medical evidence, the government has a compelling interest in protecting LGBT youth from the health risks posed by this dangerous mental health treatment.

II. PLAINTIFFS' PROPOSED ALTERNATIVES TO THE ORDINANCES ARE INADEQUATE TO ACHEIVE THE GOVERNMENT'S COMPELLING INTEREST IN PROTECTING MINORS FROM CONVERSION THERAPY

Plaintiffs wrongly contend that there are less restrictive alternatives to protect the mental health and well-being of youth in the City and County than a

prohibition of conversion therapy for minors. Because there are inherent—potentially deadly—dangers whenever a licensed professional attempts to accomplish the fixed outcome of changing a minor's sexual orientation or gender identity, there are no practical alternatives to a prohibition on licensed mental health professionals performing conversion therapy on minors.

As the District Court correctly concluded, the "less restrictive alternatives" Plaintiffs propose would still allow minors to be exposed to the very physical and mental harms caused by conversion therapy that have been identified by the nation's leading medical and medical health associations, on which the City and County relied in enacting the Ordinances. *See* Doc. 141 - Pp. 44-49.

First, there is no effective way for the Ordinances to prohibit only "coercive" and "involuntary" conversion therapy for minors. Conversion therapy is *inherently* coercive because it does not accommodate as a successful outcome any result other than conversion of the patient's sexual orientation or gender identity.

As explained by the United States Department of Health and Human Services, the "Professional Consensus on Conversion Therapy with Minors" is that: "*Interventions aimed at a fixed outcome,* such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender

expression, and sexual orientation *are coercive*, can be harmful, and should not be part of behavioral health treatments." Doc. 85-12 – Pg. 19 (emphasis added).

Simply put, the very nature of this therapy—because its goal is a fixed and predetermined outcome—makes it coercive for minors. And, it is also inherently involuntary for minors, who have no legal power or practical ability to refuse this treatment if their parents want them to be subjected to it.

Indeed, in rejecting this form of treatment as unethical and unprofessional, professional organizations have recognized the reality that any purported distinction between voluntary and involuntary treatment is meaningless in practice for minors. Minors are under the legal control of parents or guardians and thus cannot themselves decide to legally consent to, or refuse, medical care that could be dangerous to them and that provides no potential benefits. *See* Doc. 141 – Pp. 47-48.

Florida law generally does not allow children under the age of 18 to consent to their own medical treatment, leaving all such decisions in the hands of their parents. *See, e.g.,* Fla. Stat. §§ 743.064, 743.0645. Given this reality, limiting the Ordinance to instances of "involuntary" or "coercive" conversion therapy would be

meaningless; virtually all such therapy is involuntary where minors are concerned, as a matter of law.

Although Florida law permits minors age 13 years or older to consent to some mental health counseling, that exception applies only when the minor "experiences an emotional crisis," and, even then, only for short-term "diagnostic and evaluative services," not for ongoing treatment. Fla. Stat. § 394.4784. In sum, Florida law provides no avenue by which minors of any age can effectively refuse or resist conversion therapy treatments sought by their parents or other adult authorities.

For essentially the same reasons, the proposal that minors give "informed consent" before undergoing conversion therapy is not an acceptable alternative. As the Third Circuit noted in rejecting a similar argument, "[m]inors constitute an 'especially vulnerable population,' and may feel pressured to receive [conversion therapy] counseling by their families and their communities despite their fear of being harmed." *King*, 767 F.3d at 240 (quoting APA Report at 121); *see also* Doc. 122-22 – Pg. 85 (noting that minors "are emotionally and financially dependent on adults").

The District Court properly concluded that conversion therapy "is condemned by numerous professional organizations as contraindicated, harmful, and ineffective, because minors' 'immaturity, inexperience, and lack of judgment

may sometimes impair their ability to exercise their rights wisely.'" Doc. 141 – Pg. 43 (quoting *Hodgson v. Minnesota*, 497 U.S. 417, 444 (1990)). The governmental decision to protect the health and safety of these vulnerable youths is rational, is based on solid medical evidence, and is narrowly tailored to prevent harm to minors from this dangerous form of mental health treatment.

CONCLUSION

For the foregoing reasons and those stated in Defendants-Appellees' brief, amici curiae respectfully request that the Court affirm the decision of the District Court.

DATED: June 17, 2019

Respectfully submitted,

/s/ Sylvia H. Walbolt

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation, as provided in Fed. R. App. P. 29(a)(5) and 32(a)(7)(B), because, exclusive of the exempted portions of the brief, the brief contains 4,318 words.

2. This brief complies with the type-face requirements, as provided in Fed. R. App. P. 32(a)(5), and the type-style requirements, as provided in Fed. R. App. P. 32(a)(6), because the brief has been prepared in proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

3. As permitted by Fed. R. App. P. 32(g)(1), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

Dated: June 17, 2019

/s/ Sylvia H. Walbolt
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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit by using the appellate CM/ECF system on June 17, 2019. Service on all counsel will be made through the CM/ECF system.

Dated: June 17, 2019

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Addendum

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

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ABSTRACT

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

KEYWORDS

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

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

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

Existing research and field consensus

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

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

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

Adolescents, parents, and SOCE

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

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

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

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

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

The current study

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

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

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

Method

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

Sample

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

Measures

Parent-initiated efforts to change youths' sexual orientation

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

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

Young adult health and adjustment

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

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

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

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

Demographic and family characteristics

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

Plan of analysis

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

Results

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes

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

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