EXHIBIT

1

(Declaration of Christopher Rosik, Ph.D.)

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc., et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 8:17-cv-2896-T-02AAS
	)	
CITY OF TAMPA, FLORIDA,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF CHRISTOPHER ROSIK, PH.D.

I, Dr. Christopher Rosik, hereby declare as follows:

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I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of Plaintiffs. I have been asked to offer my analysis and opinions regarding the state of science on the issues of sexual orientation and gender identity, with a focus on the published quantitative literature, specifically with respect to the claimed scientific justifications for City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (hereinafter "Ordinance 2017-47"). The facts in this Declaration are true and correct, and if called upon to testify to them I would and could do so competently.

2. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am also the Director of Research. Attached hereto as Exhibit A is a copy of my curriculum vitae, which includes my qualifications and publications, including all publications I have authored in the previous ten years. I have not testified at trial or by deposition in any case during the previous four years.

3. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Exhibit B.

4. My compensation for this engagement will be $450 per hour for deposition and trial testimony, $200 per hour for travel time, and actual expenses. I provide the remainder of my time for this engagement *pro bono*.

II. SUMMARY AND PRELIMINARY CONSIDERATIONS.

5. With reference to legislation banning licensed therapists from engaging in therapies that allow for change in the components of sexual orientation generally, and specifically regarding Ordinance 2017-47, I offer below several considerations. I note at the outset that the terminology of sexual orientation change efforts (SOCE) and "conversion therapy" are in many ways misnomers. These terms imply that categorical change (from exclusive same-sex attraction to exclusive opposite sex attraction) is the goal and the focus, although change typically is on a continuum and can occur without a direct therapeutic focus on sexuality. SOCE also is not clear about what constitutes an "effort" and whether this effort is that of the client and/or the therapist. However, ethical change-allowing talk therapy is client-directed and does not impose goals on the client, but seeks instead to facilitate the voluntary goals of the client which sometimes include change. "Conversion therapy" gives the false impression that there is a singular exotic therapy being practiced when in fact ethical practitioners in this area utilize a variety of mainstream therapeutic approaches, all centered on and delivered through speech. Finally, these terms do not always distinguish between professionally conducted psychotherapy and religious or other forms of counseling practice, a blurring of categories that carries immense significance for accurately representing change-allowing professional therapies. Unfortunately, SOCE terminology is the current standard vernacular so I will employ it at times in this declaration to signify change-allowing professional talk therapies, though I recognize that licensed therapists in this area of

practice find the language of sexual attraction fluidity exploration or therapy-assisted fluidity to be more accurately descriptive of their work.

6. There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and see change-allowing therapies as a valid option for psychological care, while simultaneously affirming as well the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against professional SOCE, the information in the present declaration should be sufficient to question the scientific (not to mention constitutional) merits of Ordinance 2017-47.

7. To summarize my main points:

(1st) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of Ordinance 2017-47 portray it to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists as pertains to sexual orientation research. Notwithstanding this demonstrable bias, the scientific literature does not support the conclusion that voluntary, speech-based SOCE causes harm. In fact, the actual research studies reject causal attribution of harm to SOCE as an empirical matter, rendering any pro-SOCE-ban position statements based on the studies at best unreliable and at worst dishonest.

(2nd) Given the empirically determined fact that all therapy includes some risk of harm, and the absence of any empirical data on harm specifically from SOCE therapy, the actual degree of harm attributable to SOCE is unknowable at this time. This is a critical fact of basic research methodology.

(3rd) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery as pertains to SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(4th) An impressive body of scientific data indicates that non-heterosexual sexual orientations should not be viewed as always immutable but are often fluid and subject to change, especially among youth and young adults. Assertions to the contrary should be considered in light of Diamond and Rosky's (2016) observation that, in spite of its scientific inaccuracy, "Some advocates clearly believe that immutability claims are necessary to advocate effectively for sexual minorities" (p. 372).

(5th) The proper course of action for politicians and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not place a ban on its professional practice that supersedes existing regulatory oversight and may

create unintended consequences for licensed therapists who work with non-heterosexual clients.

III. ANALYSIS AND OPINIONS.

A. The Objectivity of the 2009 APA Task Force Report on SOCE Is Demonstrably Suspect; Therefore the Report's Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE Is Neither Complete nor Definitive.

i. Bias in Task Force Selection.

8. Although many qualified conservative psychologists were nominated to serve on the task force that published the 2009 Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (the "Report"), all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007). It appears that the APA operated with a litmus test when considering task force membership—the only views of homosexuality that were tolerated are those that uniformly endorsed same-sex behavior as a moral good. Thus, from the outset of the task force, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Report's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the task force addressed its work.

ii. Bias Regarding Statements of SOCE Harm and Efficacy.

9. This bias was particularly evident in the task force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Report dismisses most of the relevant research because of methodological limitations which are outlined in great detail (APA, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the task force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Report adopts very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Report uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that, "...it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

10. The six studies deemed by the task force to be sufficiently methodologically sound to merit the focus of the Report targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of change-allowing talk therapies employs. This brings into question the Report's willingness to move beyond scientific agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Report seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

11. There are places in the Report that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Report states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly the Report observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, 2009, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, 2009, p. 83; cf. p. 67, 120).

12. These expressions of agnosticism are justified by the task force but then are not adhered to in the Report's conclusions. Instead, the Report argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Report does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the Report goes on to assert confidently that success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the Report the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14, emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Report.

iii. Bias in Favor of Preferred Conclusions.

13. That the task force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes can be demonstrated by a few examples. The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions. First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed in the Report and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an even-handed methodological evaluation by the task force would not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There also was an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized

norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles.

14. As Hooker (1993) wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the task force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). Furthermore, the APA has cited Hooker's "rigorous" study in several of its recent amicus briefs (Schumm, 2014). The point here is not to argue for an association between homosexuality and pathology, but to underscore that a consistent application of the methodological standards affirmed in the Report should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

iv. Bias Regarding Treatment of the Primary Study on Harm.

15. Perhaps the most egregious example of the task force's methodological double standard is evidenced in their heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research in conclusions about harm from SOCE. Several methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic therapies: Documenting the damage".
- Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.
- Only 20 participants in this study were women, creating significant skew toward gay male accounts.
- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.
- Finally, these subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades prior. The task force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical*

violations in conversion therapy" (Shidlo & Schroeder, 2002, p. 250, emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from change-allowing talk therapies conducted by licensed medical and mental health professionals.

16. Again, what we can say with confidence is that some SOCE clients report harm and others report benefit and we do not know from the literature how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for legal prohibition.

v. Bias Regarding the Lack of Context Concerning Harm in Psychotherapy.

17. The APA and other professional bodies that utilize this Report, including those identified in the Ordinance, are negligent if not fraudulent in giving a warning that SOCE may potentially cause harm but failing to do so within the broader context that this warning certainly applies to all forms of psychological care for any and all forms of presenting problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

18. It should be noted in this regard that there is not a single study which provides prevalence estimates of harm from SOCE using a representative and population-based sample. The APA Report does not make this fact clear and has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013; Warren, Nelson, Burlingame, & Mondragon, 2012). In addition to psychotherapy deterioration rates, 40-60% of youth drop out of all forms of psychological treatment early (Kazdin, 1996; Nelson, et al. 2013; Wierzbicki & Perkarik, 1993).

19. These facts have considerable implications for contextualizing the alleged reports of harm and efficacy from SOCE. Deterioration rates significantly beyond 20% would need to be established for professionally conducted SOCE in order for claims of approach-specific harms among youth to be substantiated. Otherwise, Ordinance 2017-47 proponents are simply targeting one approach to psychological care on ideological and not scientific grounds.

20. Further, the high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved. This could result in a feeling of harm that would be attributable to the premature termination and not SOCE per se.

21. Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of medical and mental health difficulties *prior* to participating in any SOCE (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; Pakula, Shoveller, Ratner & Carpiano, 2016; Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since change-allowing talk therapies commonly involve helping clients become more aware of the stress and distress in their lives in order to manage or alleviate them, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre-) existing stress and distress. Thus, they may "feel worse" as a consequence of not having allowed therapy sufficient time to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high quality research that might be able to distinguish such causation simply does not exist.

vi. Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior.

22. It should also be mentioned in the discussions of harm and benefit from SOCE that the Report makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the U.S., but make up only an estimated 2-4% of men in the population (Newcomb & Mustanski, 2011). This is occurring in a context where MSM are reporting higher rates of sexual risk behaviors in recent years in spite of increasing cultural acceptance. Similarly, the disparities in emotional distress, suicidal ideation, and suicide attempts between non-heterosexual and heterosexual persons have persisted since the 1990s and even appear to be getting worse for bisexual and lesbian girls (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Porta, Watson, Doull, Eisenberg, Grumdahl, & Saewyc, 2018; Savin-Williams & Ream, 2007). Certainly, whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet desires of the client to change attractions or even homosexual behavior could jeopardize the license of the therapist under Ordinance 2017-47.

vii. Bias Regarding Research on the Origins of Same-Sex Attractions.

23. Another example of the task force's uneven application of methodological standards concerns the Report's conclusion that, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the task force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalizable sample composed of psychiatric patients. All of these

problems were considered to be fatal flaws in the task force's appraisal of the SOCE outcome literature for documenting evidence of change, but were ignored for conclusions that the task force wanted to draw.

24. Given that many of the methodological limitations used by the task force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the task force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically flawed that one cannot make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the task force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

25. If such ambiguity exists in the SOCE literature on methodological grounds, then by the task force's own criteria, this ambiguity also is present in the referenced etiological research. The task force has been inconsistent in the application of their methodological critique to the broader literature on homosexuality and they have been willing to offer more definitive conclusions about theories they wish to dismiss than is warranted by their own standards. In a word, there is again the appearance of substantial bias.

26. Contra to the repeated claims of the Report that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exists recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008, Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the task force.

27. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

28. This is underscored by the much higher prevalence rates of childhood sexual abuse (CSA) among non-heterosexuals (Andersen & Blosnich, 2013; Outlaw et al., 2011; Sweet & Wells, 2012; Xu & Zheng, 2015) and the fact that men experience more distress when sexually assaulted by a man as opposed to a woman (Artime, McCallum, & Peterson, 2014). Across relevant studies, median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman, Exner, & Baughman, 2011). Furthermore, as Xu and Zheng observe, "It is possible that CSA causes an individual to develop a same-sex sexual attraction" (p. 328). The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors

beyond physical, sexual, and emotional abuse. Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013). These researchers favor the view that attachment insecurity plays a causal role in gender atypicality, though they acknowledge that longitudinal studies are needed to confirm their suspicions. Andersen and Blosnich (2013) reported higher levels of exposure to adverse childhood factors (e.g., mentally ill, substance abusing, or incarcerated family members) for non-heterosexuals that were not likely to be the result of the child's nascent homosexuality, as is sometimes alleged as an explanation for elevated rates of physical and sexual abuse. The authors disagree but acknowledge that, "Some researchers posit that childhood adversity (particularly sexual abuse) may play a causal role in the development of same-sex preferences or sexual minority identity" (p. 5).

29. One example of this is research suggesting a causal role for childhood sexual abuse in the development of same-sexual orientation is based on a developmental and conditioning paradigm (Beard et al. 2013; Bickham et al. 2007; Hoffman, 2012; O'Keefe et al. 2014). For example, O'Keefe et al. (2014) and Beard et al. (2013) studied the effects of brother-brother incest and sister-brother incest in a sample of 1,178 men. They concluded that, "The origins of this increased interest in sex and the origins of bisexual or same-sex sexual orientations as well as the origins of many of the powerful urges to engage in behaviors such as exhibitionism or to use objects sexually can be explained as arising from early childhood experiences through the synergistic actions of critical period learning, sexual imprinting, and conditioning" (O'Keefe, et al., 2013, p. 27). These researchers also observed that such processes could account for much of the data that has been utilized to suggest a dominant biological or genetic explanation for non-heterosexuality.

viii. Bias Regarding Use of the "Grey Literature".

30. The uneven methodological implementation of standards is again seen in the Report's treatment of the "grey literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly, prospective, longitudinal study on SOCE supportive of change for some individuals and finding no harm on average and significantly improving psychological symptoms is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on page 90 of the Report; see also Jones & Yarhouse, 2011). Yet the task force appears to have no compunction in citing the grey literature on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

ix. Bias in the APA's Broader Treatment of Sexual Orientation.

31. A final differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the task force applied to the SOCE literature. The Marks study concluded that,

> "...some same-sex parenting researchers seem to have contended for an 'exceptionally clear' verdict of 'no difference' between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, 'the line between science and advocacy appears blurred'" (p. 748).

While Marks' analysis does not focus on change-allowing talk therapies, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in public policy conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the APA task force Report with the banning of professional SOCE as represented in Ordinance 2017-47.

x. The APA Report Is Not Definitive Regarding the Risk of Harm from SOCE Due to Its Scientific Shortcomings and Pervasive Bias, and This Undermines All Position Statements Based on It.

32. In addition to the pervasive bias demonstrated above, a fatal scientific flaw in the APA Report and all subsequent studies and position statements based on it is their inability to account for pre-SOCE levels of distress, which is a key component for disentangling distress attributable to a psychotherapeutic intervention and distress experienced by clients prior to ever engaging in therapy. Without this data, the actual degree of harm attributable to therapy is unknowable. This is a critical fact of basic research methodology, particularly when the population under study is known to have high levels of adverse childhood experiences. To cite only one example, non-heterosexual persons report much higher levels of childhood sexual abuse (CSA) than heterosexual persons (Friedman et al., 2011; Rothman et al., 2011: Xu & Zheng, 2015), and CSA has been linked to later suicidality (Bebbington, et al., 2009; Bedi et al., 2011; Eskin, Kaynak-Demir, & Demir, 2005). Hence, without pre-SOCE assessment of participants' suicidality, claims attributing frequent suicidal thoughts and behaviors to be the direct result of change-allowing talk therapies constitute empirically unfounded speculation.

33. To summarize, a proper conclusion regarding the 2009 APA Report and its progeny is that these reports and position statements cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and therapists to provide change-allowing professional psychotherapy. Utilizing this research to evaluate the provision of change-allowing talk therapies makes no more sense than studying a sample of former marital therapy patients who have subsequently divorced to determine the effectiveness and harm of marital therapy in general.

B. Non-heterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People and Particularly Among Females and Youth.

34. Central to the notion that some individuals can and do report change on a continuum of change in their sexual orientation is the issue of *immutability*. The APA Task Force Report said one of the "key findings in the research" on which it based its conclusion was that sexual orientation does not change through life events (APA, 2009, pp. 63, 86). Were all same-sex

attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise, including among minors. However, there is solid data to suggest that same-sex attractions and behaviors are not fixed and are subject to varying degrees of change. As summarized by Ott et al. (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). Hu, Xu, and Tornello (2016) studied longitudinal data and observed, "In the LGB [lesbian, gay, and bisexual] population, the dominant pattern was change." Dickson, van Roode, Cameron, and Paul (2013) further asserted that, "People with changing sexual attractions may be reassured to know that these are common rather than atypical (p. 762). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "...the importance of viewing sexual orientation as a process which often changes over time" and noted "...the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

i. Lack of Agreement Regarding What Constitutes Sexual Orientation.

35. Contrary to the conventional wisdom, there is substantial debate with scientific circles as to what constitutes sexual orientation, and this uncertainty extends to terms such as "sexual orientation change efforts." Sexual orientation may be said to comprise same-sex attractions, fantasies, and behaviors, but this is insufficient to guide change-allowing talk therapists in knowing clearly whether what they are discussing with a client could be considered as a *sexual orientation* change effort. That term is nebulous, and many scholars admit they have no precise means of distinguishing sexual orientation from same-sex sexuality, *i.e.*, same-sex behaviors and attractions that may not signify a same-sex orientation (Diamond, 2003). Relatedly, Savin-Williams (2016) described sexual orientation as being a continuum rather than discreet categories, which theoretically could mean that an isolated same-sex attraction among an otherwise completely heterosexual person might be considered as a separate sexual orientation.

36. Echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125). Finally, Diamond and Rosky (2016) acknowledged these problems when they indicated,

> ....it is important to note that sexual orientation is not easy to define or measure. This obviously poses a problem for research on the causes of sexual orientation, given that the first step in such research is to identify individuals with different sexual orientation. (p. 365).

One could rationally argue that this also poses a problem for the politics of SOCE ban legislation.

ii. Non-Heterosexuality Is Not a Fixed Trait.

37. The definitive study by Laumann, Gagnon et al. (1994), cited by the APA (2009) task force, involved several thousand American adults between the ages of 18 and 60. This report contains the most careful and extensive database ever obtained on the childhood experiences of

matched homosexual and heterosexual populations. One of the major findings of the Laumann, Gagnon et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely seemed to exist (Laumann, Michael, and Gagnon, 1994). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report:

> ...this implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42 percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296)

They also note that their findings comport well with other large-scale studies.

> [O]verall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys...one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

38. This data suggest that heterosexuality is normative even for those who at one point in the past reported a non-heterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among non-heterosexual individuals" (p. 104). Moch & Eiback (2010) found that heterosexuality was more stable than homosexuality or bisexuality over a 10-year period in middle aged adults. Nearly half of women with initial bi- or homosexual identity opted for a different label 10 years later. Diamond and Rosky summarize the matter well: "Given the consistency of these findings, it is no longer scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait" (p. 370).

39. Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e., heterosexual. Therefore, it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

40. Whether measured by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life occurred largely in one direction—toward heterosexuality—and reflected significant decline in non-heterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly a picture of sexual orientation stasis in adolescence that Ordinance 2017-47 seems to assume. To be fair, we cannot tell from this

data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that change-allowing talk therapies could aide some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a non-heterosexual sexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies disallowing the potential for change (e.g., "gay-affirmative") could be interfering with normal sexual development.

iii. Fluidity of Non-Heterosexual Sexual Attractions and Identity is Commonplace.

41. Diamond's longitudinal studies of women with non-heterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "Hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (italics in original, p. 13). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "...demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12).

42. Farr, Diamond, and Boker (2014) presented evidence for the existence of subtypes of non-heterosexual women, both in the intensity or degree of their same-sex attractions and in how these attractions change over time. She noted that these women appear more likely than men to specifically report the roles of circumstance, chance, and choice in their sexual identity and orientation, concluding that, "These results support the notion that some degree of plasticity may be a fundamental component of female same-sex sexuality" (p. 1487). Dickson et al. (2013) reviewed the relevant scientific literature and concluded, "These studies demonstrate that there is more change in sexual orientation than would be expected from repeated cross-sectional studies and change appears to be more common among women than men" (p. 754).

43. Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted change-allowing talk therapies as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided adequate assessment to insure voluntary and informed consent. Finally, echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

44. Although the general scholarly consensus is that non-heterosexual women are more fluid in their sexual attractions and behaviors than are men, this may not be the case. As Diamond (2017) noted, "Female sexuality was once thought to be more fluid and plastic than men's, but recent research has begun to challenge this view" (p. 1184). This includes research on sexual orientation fluidity by Katz-Wise (2015) and Katz-Wise & Hyde (2015). These researchers studied a sample of young adults (18-26 years of age) who reported a same-gender sexual orientation. They discovered that 63% of the women and 50% of the men reported fluidity in their sexual

attractions, and of these individuals 48% of the women and 34% of the men also reported change in their sexual orientation identity. Of additional import for evaluating the legitimacy of Ordinance 2017-47, participants who reported fluidity indicated that their initial experience of change in sexual attractions occurred on average *before* the age of 18.

45. More recently, Diamond (2016) reviewed relevant studies and concluded,

> The other major conclusion that we can draw from these studies is that change in patterns of same-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented...between 25% and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon. (p. 253)

46. It is also noteworthy that the Katz-Wise studies reported sexually fluid participants were more likely than sexually non-fluid participants to believe that sexual orientation is changeable. Non-sexually fluid men were more likely than sexually fluid men to believe that sexuality is something an individual is born with, while men who reported experiencing sexual fluidity were more likely than men who did not report sexual fluidity to view sexuality as changeable and subject to environmental influences. These findings may help explain the overwhelming dominance of men who provide testimony and personal anecdotes in favor SOCE bans, suggesting that non-heterosexual men who have not experienced change may assume that this is the case for all non-heterosexuals and support laws that ban professional change-allowing talk therapies for even sexually fluid male youths who freely seek assistance with their pursuit of change.

iv. Change Among Transgendered/Transsexual Individuals.

47. Intriguing research among transgendered persons finds that these individuals often report a change in their sexual orientation (Auer, Fuss, Hohne, Stalla, & Sievers, 2014). These researchers found almost 21% of their sample of 115 transsexual participants reported experiencing a change in their sexual orientation. They noted that, "Transition [surgically from one sex to the other] was not directly involved in this change, since a significant number of participants reported a change in sexual orientation prior to first psychological counseling and prior to initiation of cross-sex hormone treatment. The participants provided diverse individual explanation models, revealing that personal history, social environment as well as autoerotic feelings may impact on a change in sexual orientation" (p. 11). They observed that these changes may even be affected by personal decision, quoting one participant as stating, "While some people think that gender identity is something you acquire or learn, I think this was rather true for my alleged sexual orientation" (p. 9). While this study may raise more questions than it ultimately answers, it further undercuts an understanding of sexual orientation as a stable self-construct that is unchangeable for all persons in all circumstances.

v. Change Not Limited to Sexual Behavior.

48. A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to take place in the years prior to 21 in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

49. More recently, similar findings were reported among a sample of 116 polyamorous and monoamorous individuals (Manley, Diamond, & van Anders, 2015). The authors suggest "the prevalence of attraction shifts contradicts notions of attraction as stable and partnering behaviors and sexual identities as more fluid. Attraction shifts were far more common than shifts in either sexual identity or partner gender" (p. 177).

vi. Change Particularly Evident for Youth and Bisexuals.

50. A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy as it focused on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under 16 years of age and concluded when participants were nearly 22 years old. The authors observed a similar decline in non-heterosexuality over the time of the study: "All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, 16-year-olds who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately 25 times more likely to change toward heterosexuality at the age of 17 than those with exclusively opposite sex attractions are likely to move towards bisexual or exclusively same-sex attractions (Whitehead & Whitehead, 2010). Ninety-eight percent of 16 to 17-year-olds moved from homosexuality or bisexuality towards heterosexuality over the course of the study.

51. To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that Ordinance 2017-47 does not discriminate in its prohibition between SOCE provided for exclusively same-sex attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the bill's ban distinguish between boys and girls. Savin-Williams and Ream observed that, "The instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals" (p. 393). They acknowledged that developmental processes are involved even as they focused mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers

is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to change-allowing talk therapies and only allow affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can only be homosexual.

52. Ordinance 2017-47's intent for a blanket prohibition on SOCE for all minors with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw in its inability to address the complex realities of sexual orientation. For example, a study by Herek et al. (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in change-allowing talk therapies for some individuals who voluntarily desire and seek such change. Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other studies confirm the particular instability of a bisexual sexual orientation (Savin-Williams, Joyner, & Rieger, 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of Ordinance 2017-47. At a minimum, such data suggest that proponents of the Ordinance would have done better to exclude bisexuality from the scope of this bill. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that change-allowing talk therapies might augment this process for some individuals with unwanted same-sex attractions and behaviors?

vii. Identification of the Mostly Heterosexual Orientation.

53. Further evidence that Ordinance 2017-47 ignores distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2-3% men and 10-16% of women over time and constituted a sexual orientation larger than all other non-heterosexual identities combined (Savin-Williams, Joyner, & Rieger, 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other non-heterosxual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent physiological evidence in a sample of men (Savin-Williams, Rieger, & Rosenthal, 2013). This apparently viable and unique group of non-heterosexuals raises serious questions for the scope of Ordinance 2017-47; namely, are "mostly heterosexual" minors exempt from the law's ban on SOCE? The fact that the Ordinance is oblivious to such important nuances highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding change-allowing talk therapies at the behest of activists within and outside professional organizations.

54. All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth) and that this change is best conceptualized as occurring on a continuum

and not as an all-or-nothing experience. The experience of clinicians who engage in change-allowing talk therapies is that while some clients report complete change, and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity.

55. Descriptions of licensed therapists engaged in SOCE as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (see Alliance for Therapeutic Choice and Scientific Integrity (ATSCI), 2018). Licensed therapists who provide change-allowing care recognize that change of sexual orientation typically occurs on a continuum of change, and this is consistent with how change is understood to occur for most if not all other psychological and behavioral conditions addressed in psychotherapy.

viii. Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

56. Moreover, such fluidity and change make clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth and there is no convincing evidence that biology is determinative for many if not most individuals (Diamond & Rosky, 2016). The American Psychiatric Association has observed that, "...to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau et al. (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation...Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation."

57. It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008a; emphases added).

Yet the APA has made minimal effort to publicize the change in its official position on such causation or to correct the accompanying popular misconception – often promoted by the media – that persons with same-sex attractions are simply "born that way" and "can't change." It is difficult not to perceive this as significant professional neglect.

58. The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large scale studies of identical twins. These studies indicate that if one twin sibling has a non-heterosexual orientation the other sibling shares this orientation only about 11% of the time with upper estimates at 24% (v, Dunne, & Martin, 2000; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Xu, Norton, & Rahman, 2019). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence in the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses. Xu and colleagues (2019) concluded, "Thus, most of the differences between people in their sexual orientation are due to environmental factors (often nonshared) pointing to multiple etiology" (p. 1).

59. Similarly, heritability of sexual orientation is approximately .32, indicating that 32% of the population variability in sexual orientation is due to genetic factors (Diamond & Rosky, 2016). Heritability is the variability between persons in a population, not an indicator of the relative contributions of genetic and environmental influences within individuals. Diamond and Rosky put this in perspective by stating, "...it is helpful to note that higher estimations of heritability (ranging from .4 to .6) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction" (p. 366). Given these statistics, it is curious that, for example, smoking is a behavior considered subject to change, while proponents of SOCE bans often maintain sexual orientation is an immutable behavioral characteristic.

60. Causatively, then, sexual orientation is by no means comparable to a characteristic such as race or biological sex which are thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices such as those which might be facilitated in change-allowing therapies. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of Ordinance 2017-47's portrayal of same-sex attractions and behaviors as static traits only to be embraced by those minors who might otherwise desire the option of exploring change.

C. The Reality of Sexual Fluidity Underscores the Impropriety of Prohibiting Change-Allowing Talk Therapies.

61. Although no reputable scholar can now deny that the components of sexual orientation evidence significant fluidity for many non-heterosexual persons, the adamant contention of SOCE ban supporters is that such naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-allowing talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-allowing talk therapies often address these exact influences with their clients. For example, same-sex attraction fluidity is known to sometimes occur in response to changes in emotional and romantic attachments. Hu et al. (2016) reported, "The results suggested that people who report same-sex attractions with no

relationship or an opposite sex partner were more likely to shift their same-sex attractions than those who reported a same-sex relationship" (p. 658). In evaluating neurobiological research, Diamond and Rosky (2016) noted that "...one possibility [for shifts in sexual attractions] is that the formation of emotional attachments may facilitate unexpected changes in sexual desire" (p. 370). Similarly, Manely et al. (2015) assert, "...research on sexual fluidity suggest that, for some people, relationships may in fact influence sexual orientation, meaning that emotionally intimate relationships may lead to sexual attractions toward a gender to which one had not previously been attracted" (p. 168). Change-allowing talk therapy may address exactly such influences, assisting clients with their relationships in ways that for some may facilitate genuine shifting in sexual attractions and behaviors.

62. At this point in time there are only political as opposed to theoretical obstacles to acknowledging some people can be their own agents of change in a process assisted by change-allowing talk therapy, including minors. Therapists who engage in this work report such experiences with some regularity, though certainly not for all clients. Research in this arena is of course very desirable, but hard to come by, for many reasons. Demands for such research seem to ignore the fact that (1) it is quite difficult to study a therapy process that is being made illegal, (2) funding sources for such research typically have vested interests in the outcomes as do the researchers, (3) obtaining findings favorable in any way to change-allowing talk therapies will likely result in the marginalization and professional ostracization of the researcher (Wood, 2013). It appears there will need to be a change, or at least a significant shifting, in the ideologically unbalanced professional culture of psychology before we can undo the current politically required foreclosure on the science of talk therapy-assisted fluidity in same-sex attractions and behaviors. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148).

D. Professional SOCE Bans Target Speech, Not Aversive Practices.

63. There is now clear evidence from state legislative proceedings that the intent of bans such as Ordinance 2017-47 is to stifle therapist speech and not certain aversive practices. Across the country where ban legislation for minors has been debated, politicians are hearing testimonials that directly or by implication associate SOCE provided by licensed therapists with painful aversive techniques such as shocking genitals, chemically induced vomiting, taking ice baths, and the like. This caricature of contemporary change-allowing talk therapies as promoting such child abuse is both disingenuous and slanderous, as was revealed in the legislative process surrounding proposed therapy bans in the states of Washington in 2015 and Utah in 2019. In both instances, amendments were made in committee that would have preserved a legal prohibition on the harmful aversive techniques but would have specially protected therapist speech. In the Utah example, the amendment would even have penalized guarantees of "a complete and permanent reversal in the patient or client's sexual orientation."

64. Nevertheless, despite the prospect of bipartisan support for these bills, proponents pulled the legislation, complaining they did not go far enough despite their targeting of the same aversive practices that were prominently mentioned as a basis for these bans (Backholm, 2015; "Watered down anti-conversion therapy bill," 2019). Particularly telling were the comments by

University of Utah College of Law professor Clifford Rosky, who developed the original ban bill in Utah, as reported in the local gay press:

> "Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades," Rosky continued. What they do these days, he said was talk therapy. "As we know, words are just as damaging to children."

Clearly then, proponents of change-allowing talk therapy bans have known all along that allowing abusive aversive practices to be associated with contemporary professional SOCE is a fundamentally dishonest political maneuver. Politicians and judges need to hear from ban proponents examples of what specific words change-allowing talk therapy practitioners say to minors that creates damage on a par with electroshocking their genitals.

E. State Regulatory Boards Already Are Equipped to Discipline Abusive Practitioners.

65. If any minors in the care of licensed therapists have been subjected to any of the aversive practices often declared by ban proponents, it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. This raises a question for proponents of bans such as Ordinance 2017-47: Are these bans a solution to a problem that does not exist for minor clients of licensed therapists?

66. State regulatory boards exist and are funded for the purposes of addressing exactly the kinds of unacceptable aversive practices ban proponents claim is occurring with some licensed SOCE providers. It is imperative any concerns along these lines be addressed by a state regulatory body of other therapists who have the training and expertise to ensure ethical counseling practices. Such a body will understand the nuances of psychotherapeutic work and hence be in a position to accurately determine genuine malpractice. Given that mental health professionals who engage in change-allowing therapies have expended great amounts of time and money on their education and careers and have much to lose, genuine justice demands any questions about their therapy-related speech be adjudicated by their professional peers in state regulatory agencies. Untrained politicians and city officials are by no means qualified to police professional practice issues, including the goals and content of therapy offered by licensed mental health practitioners.

IV. Concluding Statements

67. As this declaration has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA task force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the task force noted, the prevalence of success and harm from SOCE cannot be determined at present, and recent SOCE research does not advance the field sufficiently to provide a scientific basis for ban legislation. Anecdotal accounts of harm, which are a focal point of attention by supporters of bans such as Ordinance 2017-47, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal

level. It is negligent if not fraudulent that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better documented claims that experiences of SOCE were "beneficial," and were not "harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from change-allowing talk therapies (see http://voicesofchange.net; https://changedmovement.com/). Furthermore, as observed earlier, accounts of harm cannot tell us if the prevalence of reported harm from change-allowing therapies is any greater than that from psychotherapy in general.

68. The normative occurrence of spontaneous change in sexual orientation among youth and adults and the nontrivial degree of choice reported by some in the development of sexual orientation further bring into question the appropriateness of Ordinance 2017-47. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, high quality research is needed to confirm clinical reports of change. However, it should be mentioned in this regard that Ordinance 2017-47 would make further research on change-allowing talk therapies with minors impossible in Tampa, despite the APA task force's clear mandate that such research be conducted (APA, 2009).

69. Any purported concerns of harm anecdotally attributed to SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. Ordinance 2017-47 is a legislative overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and non-heterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by Ordinance 2017-47, a distinction this law does not make.

70. Proponents of Ordinance 2017-47 reason that because homosexuality is no longer considered to be a disorder, providing change-allowing talk therapies to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention Ordinance 2017-47 gives to SOCE again hints at political advocacy rather than science as a primary inspiration for this law.

71. Clients will not be well served if change-allowing talk therapy with minors is judged *never* to be an appropriate modality for psychological care. Neither the courts nor the professional associations should be substituting their judgment for that of a 17-year old who is calculating a cost-benefit analysis in deciding whether to undergo change-allowing talk therapy, understanding through informed consent that fluidity in unwanted same-sex attractions may or may not occur. The APA is quite clear that it supports the competence of a 17-year old girl to give

consent to an abortion. Why does the 17-year old lose competence when it comes to change-allowing talk therapies?

72. Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b) and Ordinance 2017-47 implicitly protects this option. Is it reasonable that 17-year olds who experience themselves to be the wrong biological sex be allowed to surgically remove breasts and alter genitalia while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of high quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne, et al., 2011).

73. The task force Report (APA, 2009), and the mental health associations that subsequently relied on it for their resolutions on SOCE, including those cited in the Ordinance, provide one viewpoint into research and reasoning which must be considered incomplete and therefore not definitive enough to justify a complete ban on change-allowing therapies with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Duarte et al., 2015; Redding, 2001), which has an inhibitory influence on the production of scholarship in controversial areas such as change-allowing talk therapies that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> "In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons...This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board)" (p. 90).

Such diversity is precisely what is lacking currently in professional mental health organizations and their associated scientific communities as regards the study of contested social issues related to sexual orientation, including SOCE (Duarte et al., 2015; Wright & Cummings, 2005). It would hard to understand, for example, how the leadership of the National Association of Social Workers could endorse a total of 542 candidates in federal elections between 2014 and 2018—all of whom were affiliated with the Democratic Party (NASW, 2018). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011).

74. The APA lost 10% of its members between 2008 and 2013 and now represents less than 44% of psychologists in America (Robiner, Fossum, & Hong, 2015). The American Medical Association now represents less than 20% of physicians in the country. These downward trends have in part come about due to these associations' taking left-of-center positions on several social and policy issues, alienating conservative members and leading many of them to disaffiliate. It is evident from these kinds of statistics that, when it comes to socially contentious issues such as

change-allowing talk therapies, the mental health and medical associations likely do not speak for many of those professionals who practice in their respective fields.

75. To repeat a final time, a truly scientific response to the concerns of the sponsors of Ordinance 2017-47 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. Change-allowing talk therapy practitioners take seriously their responsibility to do no harm and would assuredly embrace such an opportunity (Jones, et al., 2010). Were proponents of Ordinance 2017-47 not playing a winner-take-all approach to the issue of professional SOCE, there would undoubtedly be substantial ground both sides could agree upon that would address concerns regarding alleged harms and reported benefits from change-allowing talk therapies. Unfortunately, the approach taken by Ordinance 2017-47 sponsors represented only one (political and legislative) perspective on how to best address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. It is therefore a scientifically premature, and therefore unjust, violation of the rights of current and potential change-allowing talk therapy consumers, their parents, and their therapists and should not be allowed to stand.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this May 6, 2019.

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5/88 - Present	Licensed clinical psychologist, Link Care Center, Fresno, California.
11/94 - 6/96	Assistant Clinical Director, Link Care Center, Fresno, California.
7/96 - 12/99	Clinical Director, Link Care Center, Fresno, California.
1/01 – Present	Clinical Faculty, Fresno Pacific University
1/05 – Present	Director of Research, Link Care Center, Fresno, California

IV. Professional Affiliations.

1/84 - Present	Member, American Psychological Association.
1/86 - Present	Member, Christian Association for Psychological Studies (CAPS).
6/90 - 6/93	Member, board of directors, CAPS-Western region.
6/01 – 5/05	President-Elect, President, and Past-President, CAPS-Western Region
1/92 - Present	Member, International Society for the Study of Dissociation.
7/99 – Present	Member, Alliance for Therapeutic Choice and Scientific Integrity (Alliance)
1/11 – 12/17	President-Elect, President, and Past President, Alliance
1/11 - Present	Member, National Association of Social Workers.

V. Selected Publications.

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EXHIBIT

1

(Declaration of Christopher Rosik, Ph.D.)

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc., et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Case No. 8:17-cv-2896-T-02AAS
	)	
CITY OF TAMPA, FLORIDA,	)	
	)	
Defendant.	)	
	)	

DECLARATION OF CHRISTOPHER ROSIK, PH.D.

I, Dr. Christopher Rosik, hereby declare as follows:

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I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of Plaintiffs. I have been asked to offer my analysis and opinions regarding the state of science on the issues of sexual orientation and gender identity, with a focus on the published quantitative literature, specifically with respect to the claimed scientific justifications for City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (hereinafter "Ordinance 2017-47"). The facts in this Declaration are true and correct, and if called upon to testify to them I would and could do so competently.

2. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am also the Director of Research. Attached hereto as Exhibit A is a copy of my curriculum vitae, which includes my qualifications and publications, including all publications I have authored in the previous ten years. I have not testified at trial or by deposition in any case during the previous four years.

3. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Exhibit B.

4. My compensation for this engagement will be $450 per hour for deposition and trial testimony, $200 per hour for travel time, and actual expenses. I provide the remainder of my time for this engagement *pro bono*.

II. SUMMARY AND PRELIMINARY CONSIDERATIONS.

5. With reference to legislation banning licensed therapists from engaging in therapies that allow for change in the components of sexual orientation generally, and specifically regarding Ordinance 2017-47, I offer below several considerations. I note at the outset that the terminology of sexual orientation change efforts (SOCE) and "conversion therapy" are in many ways misnomers. These terms imply that categorical change (from exclusive same-sex attraction to exclusive opposite sex attraction) is the goal and the focus, although change typically is on a continuum and can occur without a direct therapeutic focus on sexuality. SOCE also is not clear about what constitutes an "effort" and whether this effort is that of the client and/or the therapist. However, ethical change-allowing talk therapy is client-directed and does not impose goals on the client, but seeks instead to facilitate the voluntary goals of the client which sometimes include change. "Conversion therapy" gives the false impression that there is a singular exotic therapy being practiced when in fact ethical practitioners in this area utilize a variety of mainstream therapeutic approaches, all centered on and delivered through speech. Finally, these terms do not always distinguish between professionally conducted psychotherapy and religious or other forms of counseling practice, a blurring of categories that carries immense significance for accurately representing change-allowing professional therapies. Unfortunately, SOCE terminology is the current standard vernacular so I will employ it at times in this declaration to signify change-allowing professional talk therapies, though I recognize that licensed therapists in this area of

practice find the language of sexual attraction fluidity exploration or therapy-assisted fluidity to be more accurately descriptive of their work.

6. There should be no doubt that licensed mental health professionals who practice some form of SOCE care deeply about the well-being of sexual minority youth and see change-allowing therapies as a valid option for psychological care, while simultaneously affirming as well the client's right to pursue gay affirmative forms of psychotherapy. While it is not possible here to respond to all the accusations that are typically leveled against professional SOCE, the information in the present declaration should be sufficient to question the scientific (not to mention constitutional) merits of Ordinance 2017-47.

7. To summarize my main points:

(1st) The science as pertains to SOCE efficacy and harm is not nearly as conclusive and definitive as proponents of Ordinance 2017-47 portray it to be. Their one-sided presentation of the science is a byproduct of a pervasive lack of viewpoint diversity within professional organizations and their constituent social scientists as pertains to sexual orientation research. Notwithstanding this demonstrable bias, the scientific literature does not support the conclusion that voluntary, speech-based SOCE causes harm. In fact, the actual research studies reject causal attribution of harm to SOCE as an empirical matter, rendering any pro-SOCE-ban position statements based on the studies at best unreliable and at worst dishonest.

(2nd) Given the empirically determined fact that all therapy includes some risk of harm, and the absence of any empirical data on harm specifically from SOCE therapy, the actual degree of harm attributable to SOCE is unknowable at this time. This is a critical fact of basic research methodology.

(3rd) Professional activism and related advocacy interests have superseded allegiance to the process of scientific discovery as pertains to SOCE, as is evident in the highly discrepant methodological standards professional organizations have utilized to evaluate efficacy and harm.

(4th) An impressive body of scientific data indicates that non-heterosexual sexual orientations should not be viewed as always immutable but are often fluid and subject to change, especially among youth and young adults. Assertions to the contrary should be considered in light of Diamond and Rosky's (2016) observation that, in spite of its scientific inaccuracy, "Some advocates clearly believe that immutability claims are necessary to advocate effectively for sexual minorities" (p. 372).

(5th) The proper course of action for politicians and the courts to take given the current limited scientific base of knowledge regarding SOCE should be to encourage further and ideologically diverse research, not place a ban on its professional practice that supersedes existing regulatory oversight and may

create unintended consequences for licensed therapists who work with non-heterosexual clients.

III. ANALYSIS AND OPINIONS.

A. The Objectivity of the 2009 APA Task Force Report on SOCE Is Demonstrably Suspect; Therefore the Report's Representation of the Relevant Literature Concerning Efficacy of and Harm from SOCE Is Neither Complete nor Definitive.

i. Bias in Task Force Selection.

8. Although many qualified conservative psychologists were nominated to serve on the task force that published the 2009 Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (the "Report"), all of them were rejected. This fact was noted in a book co-edited by a past-president of the APA (Yarhouse, 2009). The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Carey, 2007). It appears that the APA operated with a litmus test when considering task force membership—the only views of homosexuality that were tolerated are those that uniformly endorsed same-sex behavior as a moral good. Thus, from the outset of the task force, it was predetermined that conservative or religious viewpoints would only be acceptable when they fit within their pre-existing worldview. One example of this is the Report's failure to recommend any religious resources that adopt a traditional or conservative approach to addressing conflicts between religious beliefs and sexual orientation. This bias can hardly be said to respect religious diversity and had predictable consequences for how the task force addressed its work.

ii. Bias Regarding Statements of SOCE Harm and Efficacy.

9. This bias was particularly evident in the task force's highly uneven implementation of standards of scientific rigor in the utilization and evaluation of published findings pertaining to SOCE (Jones, et al., 2010). Of particular note is the contrast between the exceptionally rigorous methodological standards applied to SOCE outcomes and the considerably less rigorous and uneven standards applied to the question of harm. With regard to SOCE outcomes, the Report dismisses most of the relevant research because of methodological limitations which are outlined in great detail (APA, 2009, pp. 26-34). Studies pertaining to SOCE outcomes that fall short of the task force's rigorous standards are deemed unworthy of examination and dismissed as containing no evidence of value to the questions at hand. Meanwhile, the Report adopts very different evidentiary standards for making statements about harms attributed to SOCE. The standard as regards efficacy is to rule out substandard studies as irrelevant; however, no such standards are employed in considering studies purporting to document harm. In addition, the Report uses the absence of evidence to argue that SOCE is unlikely to produce change and thus strongly questions the validity of SOCE, but shows no parallel reticence to endorse affirmative therapy despite acknowledging that, "...it has not been evaluated for safety and efficacy" (APA, 2009, p. 91).

10. The six studies deemed by the task force to be sufficiently methodologically sound to merit the focus of the Report targeted samples that would bear little resemblance to those seeking SOCE today and used long outdated methods that no current practitioner of change-allowing talk therapies employs. This brings into question the Report's willingness to move beyond scientific agnosticism (i.e., that we do not know the prevalence of success or failure in SOCE) to argue affirmatively that sexual orientation change is uncommon or unlikely. The Report seems to affirm two incompatible assertions: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change and b) we know with scientific certainty that sexual orientation change is unlikely. However, the absence of conclusive evidence of effectiveness is not logically equivalent to positive evidence of ineffectiveness (Altman & Bland, 1995).

11. There are places in the Report that do seem to acknowledge that, given their methodological standards, we really cannot know anything scientifically definitive about the efficacy of or harms attributable to SOCE. For example, the Report states, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (APA, 2009, p. 42). Similarly the Report observes, "Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective" (APA, 2009, p. 43). Similarly, "[T]here are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (APA, 2009, p. 83; cf. p. 67, 120).

12. These expressions of agnosticism are justified by the task force but then are not adhered to in the Report's conclusions. Instead, the Report argues at length that only the most rigorous methodological designs can clearly establish a causal relationship between SOCE methods and subsequent change, but the Report does not hesitate to make such causal attributions consistently regarding harm while repudiating any such claims for efficacy. From this highly uneven application of literature review methodology, the Report goes on to assert confidently that success of SOCE is unlikely and that SOCE has the potential to be harmful. It is also telling that in subsequent references to the Report the potential for harm has morphed into "the potential to cause harm to *many* clients" (APA, 2012, p. 14, emphasis added). The harms from SOCE appear to grow greater the farther away one gets from the original Report.

iii. Bias in Favor of Preferred Conclusions.

13. That the task force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes can be demonstrated by a few examples. The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions. First, consider the work of Hooker (1957), which is routinely touted as groundbreaking in the field and affirmed in the Report and other APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains such serious methodological flaws that it is inconceivable that an even-handed methodological evaluation by the task force would not have mentioned these problems. Among the many methodological problems noted by Schumm (2012), the control group was told the purpose of the study in advance, and clinical experts were not blind to the objectives of the study. There also was an imperfect matching of participants, low scale reliability, the use of a small and recruited control group rather than existent national standardized

norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles.

14. As Hooker (1993) wrote many years later, "I knew the men for whom the ratings were made, and I was certain as a clinician that they were relatively free of psychopathology." Despite these serious methodological problems, which would never be tolerated by the task force were this SOCE-supportive research, APA experts such as Gregory Herek described Hooker's study as part of the "overwhelming empirical evidence" that there is no association of sexual orientation with psychopathology (Herek, 1991, p. 143; see also Herek, 2010). Furthermore, the APA has cited Hooker's "rigorous" study in several of its recent amicus briefs (Schumm, 2014). The point here is not to argue for an association between homosexuality and pathology, but to underscore that a consistent application of the methodological standards affirmed in the Report should have led to the dismissal of the Hooker study as supportive of the no differences hypothesis.

iv. Bias Regarding Treatment of the Primary Study on Harm.

15. Perhaps the most egregious example of the task force's methodological double standard is evidenced in their heavy reliance on the Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) research in conclusions about harm from SOCE. Several methodological problems cited to dismiss the SOCE outcome literature complicate these studies:

- These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners. This was abundantly clear in the study's original title: "Homophobic therapies: Documenting the damage".

- Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure.

- Only 20 participants in this study were women, creating significant skew toward gay male accounts.

- Twenty-five percent of study participants had already attempted suicide *before* starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.

- Finally, these subjects reported their experiences came from a mix of licensed therapists, nonlicensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training.

The Shidlo and Schroeder (2002) and Schroeder and Shidlo (2003) results thus are based on a non-representative sample likely to be heavily biased in the direction of retrospectively reporting negative therapy experiences, some of which occurred decades prior. The task force appears to have ignored the warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical*

violations in conversion therapy" (Shidlo & Schroeder, 2002, p. 250, emphases in the original). It is difficult to understand how this research can be cited without qualification or context as demonstrating likely harm from change-allowing talk therapies conducted by licensed medical and mental health professionals.

16. Again, what we can say with confidence is that some SOCE clients report harm and others report benefit and we do not know from the literature how often either outcome occurs. While harm may occur with any form of psychological care, the "evidence" provided in this study is essentially nothing more than unverifiable "hearsay." This is hardly a legitimate ground for legal prohibition.

v. Bias Regarding the Lack of Context Concerning Harm in Psychotherapy.

17. The APA and other professional bodies that utilize this Report, including those identified in the Ordinance, are negligent if not fraudulent in giving a warning that SOCE may potentially cause harm but failing to do so within the broader context that this warning certainly applies to all forms of psychological care for any and all forms of presenting problems or concerns. For example, regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients, especially those who begin therapy with a severe "initial level of disturbance" (Lambert & Ogles, 2004, p. 117). Clients who experience significant negative counter-transference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

18. It should be noted in this regard that there is not a single study which provides prevalence estimates of harm from SOCE using a representative and population-based sample. The APA Report does not make this fact clear and has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general, where research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013; Warren, Nelson, Burlingame, & Mondragon, 2012). In addition to psychotherapy deterioration rates, 40-60% of youth drop out of all forms of psychological treatment early (Kazdin, 1996; Nelson, et al. 2013; Wierzbicki & Perkarik, 1993).

19. These facts have considerable implications for contextualizing the alleged reports of harm and efficacy from SOCE. Deterioration rates significantly beyond 20% would need to be established for professionally conducted SOCE in order for claims of approach-specific harms among youth to be substantiated. Otherwise, Ordinance 2017-47 proponents are simply targeting one approach to psychological care on ideological and not scientific grounds.

20. Further, the high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved. This could result in a feeling of harm that would be attributable to the premature termination and not SOCE per se.

21. Furthermore, it must be remembered that, on average, persons with same-sex attraction already experience and/or are at greater risk for experiencing a number of medical and mental health difficulties *prior* to participating in any SOCE (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; Pakula, Shoveller, Ratner & Carpiano, 2016; Whitehead & Whitehead, 2010). This makes it extremely difficult to disentangle psychological distress directly attributable to SOCE from that which preceded commencement of SOCE. And since change-allowing talk therapies commonly involve helping clients become more aware of the stress and distress in their lives in order to manage or alleviate them, as do many approaches to mental health care, persons who leave therapy prematurely may have an increased awareness or experience of their (pre-) existing stress and distress. Thus, they may "feel worse" as a consequence of not having allowed therapy sufficient time to help resolve the difficulties. Anecdotal personal stories of harm certainly cannot scientifically establish the proportion of distress derived directly from SOCE, and high quality research that might be able to distinguish such causation simply does not exist.

vi. Bias in the Omission of Medical Outcomes Associated with Same-Sex Behavior.

22. It should also be mentioned in the discussions of harm and benefit from SOCE that the Report makes no mention of the well-documented medical outcomes associated with homosexual and bisexual behavior. For example, men having sex with men (MSM) comprise 48% of all individuals with HIV/AIDS in the U.S., but make up only an estimated 2-4% of men in the population (Newcomb & Mustanski, 2011). This is occurring in a context where MSM are reporting higher rates of sexual risk behaviors in recent years in spite of increasing cultural acceptance. Similarly, the disparities in emotional distress, suicidal ideation, and suicide attempts between non-heterosexual and heterosexual persons have persisted since the 1990s and even appear to be getting worse for bisexual and lesbian girls (Peter, Edkins, Watson, Adjei, Homma, & Saewyc, 2017; Porta, Watson, Doull, Eisenberg, Grumdahl, & Saewyc, 2018; Savin-Williams & Ream, 2007). Certainly, whatever unclear risk of harm that might occur to an individual SOCE minor client must be weighed against the clear medical risks that arise from enacting homosexual behavior, particularly salient among adolescents. Yet desires of the client to change attractions or even homosexual behavior could jeopardize the license of the therapist under Ordinance 2017-47.

vii. Bias Regarding Research on the Origins of Same-Sex Attractions.

23. Another example of the task force's uneven application of methodological standards concerns the Report's conclusion that, "Studies failed to support theories that regarded family dynamics, gender identity, or trauma as factors in the development of sexual orientation" (APA, 2009, p. 23). Of the ten studies cited in support of this conclusion, three were not readily accessible on databases and one was a review article, which is an interpretation and not an empirical study. An examination of the remaining six studies (Bell, Weinberg, & Hammersmith, 1981; Freund & Blanchard, 1983; McCord, McCord, & Thurber, 1962; Peters & Cantrell, 1991; Siegelman, 1981; Townes, Ferguson, & Gillam, 1976) revealed many of the same methodological flaws cited in the task force critique of SOCE (Rosik, 2012). For example, the Freud and Blanchard study is cited as evidence against any role of family dynamics or trauma in the origin of same-sex attractions but contains many serious methodological problems, including unclear scale reliability, participants being known to the researchers as patients, the use of a convenience sample, and a narrow and therefore non-generalizable sample composed of psychiatric patients. All of these

problems were considered to be fatal flaws in the task force's appraisal of the SOCE outcome literature for documenting evidence of change, but were ignored for conclusions that the task force wanted to draw.

24. Given that many of the methodological limitations used by the task force to assail the SOCE research exist in the literature exploring the possible causal influences for sexual orientation, questions have to be raised as to why the task force members chose to definitively dismiss this literature as "failing to support" developmental theories. It appears, based on the same criteria they used to dismiss SOCE, that their own conclusions have little support in the literature. A fairer rendering of the literature they reference in this regard would appear to be that this research is so methodologically flawed that one cannot make any conclusive statements concerning the applicability of developmental factors in the origin of homosexuality. Thus by the task force's own methodological standards, the literature they cite fails to support *or rule out* a role for these potential developmental influences in the genesis of sexual orientation.

25. If such ambiguity exists in the SOCE literature on methodological grounds, then by the task force's own criteria, this ambiguity also is present in the referenced etiological research. The task force has been inconsistent in the application of their methodological critique to the broader literature on homosexuality and they have been willing to offer more definitive conclusions about theories they wish to dismiss than is warranted by their own standards. In a word, there is again the appearance of substantial bias.

26. Contra to the repeated claims of the Report that it is an established "scientific fact" that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (APA, 2009, p. 86), there currently exists recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008, Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the task force.

27. It is perfectly reasonable to believe that *not* offering professional SOCE to some minors with unwanted same-sex attractions and behaviors who seek such care *may actually harm* them by *not* helping them deal with what is one of the possible consequences of sexual molestation and abuse.

28. This is underscored by the much higher prevalence rates of childhood sexual abuse (CSA) among non-heterosexuals (Andersen & Blosnich, 2013; Outlaw et al., 2011; Sweet & Wells, 2012; Xu & Zheng, 2015) and the fact that men experience more distress when sexually assaulted by a man as opposed to a woman (Artime, McCallum, & Peterson, 2014). Across relevant studies, median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman, Exner, & Baughman, 2011). Furthermore, as Xu and Zheng observe, "It is possible that CSA causes an individual to develop a same-sex sexual attraction" (p. 328). The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors

beyond physical, sexual, and emotional abuse. Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013). These researchers favor the view that attachment insecurity plays a causal role in gender atypicality, though they acknowledge that longitudinal studies are needed to confirm their suspicions. Andersen and Blosnich (2013) reported higher levels of exposure to adverse childhood factors (e.g., mentally ill, substance abusing, or incarcerated family members) for non-heterosexuals that were not likely to be the result of the child's nascent homosexuality, as is sometimes alleged as an explanation for elevated rates of physical and sexual abuse. The authors disagree but acknowledge that, "Some researchers posit that childhood adversity (particularly sexual abuse) may play a causal role in the development of same-sex preferences or sexual minority identity" (p. 5).

29. One example of this is research suggesting a causal role for childhood sexual abuse in the development of same-sexual orientation is based on a developmental and conditioning paradigm (Beard et al. 2013; Bickham et al. 2007; Hoffman, 2012; O'Keefe et al. 2014). For example, O'Keefe et al. (2014) and Beard et al. (2013) studied the effects of brother-brother incest and sister-brother incest in a sample of 1,178 men. They concluded that, "The origins of this increased interest in sex and the origins of bisexual or same-sex sexual orientations as well as the origins of many of the powerful urges to engage in behaviors such as exhibitionism or to use objects sexually can be explained as arising from early childhood experiences through the synergistic actions of critical period learning, sexual imprinting, and conditioning" (O'Keefe, et al., 2013, p. 27). These researchers also observed that such processes could account for much of the data that has been utilized to suggest a dominant biological or genetic explanation for non-heterosexuality.

viii. Bias Regarding Use of the "Grey Literature".

30. The uneven methodological implementation of standards is again seen in the Report's treatment of the "grey literature," which is dismissed in favor of only peer-reviewed scientific journal articles in the assessment of SOCE. No developed rationale is offered for this choice. Consequently, a highly scholarly, prospective, longitudinal study on SOCE supportive of change for some individuals and finding no harm on average and significantly improving psychological symptoms is dismissed in a footnote (Jones & Yarhouse, 2007; the footnote is found on page 90 of the Report; see also Jones & Yarhouse, 2011). Yet the task force appears to have no compunction in citing the grey literature on other subjects, such as the demographics relating to sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994) or the issue of psychological and familial factors in the development of sexual orientation (Bell, et al., 1981), even though the latter book utilizes a sample of questionable representativeness.

ix. Bias in the APA's Broader Treatment of Sexual Orientation.

31. A final differential application of methodological critique highlights the systemic nature of this problem within the broader literature pertaining to homosexuality. A recent analysis of the 59 research studies cited in the APA's brief supporting same-sex parenting (Marks, 2012) in essence applied methodological standards of similar rigor to those the task force applied to the SOCE literature. The Marks study concluded that,

> "...some same-sex parenting researchers seem to have contended for an 'exceptionally clear' verdict of 'no difference' between same-sex and heterosexual parents since 1992. However, a closer examination leads to the conclusion that strong, generalized assertions, including those made by the APA Brief, were not empirically warranted. As noted by Shiller (2007) in *American Psychologist*, 'the line between science and advocacy appears blurred'" (p. 748).

While Marks' analysis does not focus on change-allowing talk therapies, it is relevant in that it underscores that APA's worldview regarding homosexuality appears to result in public policy conclusions (whether right or wrong) that go beyond what the data can reasonably support. This is precisely what appears to be occurring in linking the APA task force Report with the banning of professional SOCE as represented in Ordinance 2017-47.

x. The APA Report Is Not Definitive Regarding the Risk of Harm from SOCE Due to Its Scientific Shortcomings and Pervasive Bias, and This Undermines All Position Statements Based on It.

32. In addition to the pervasive bias demonstrated above, a fatal scientific flaw in the APA Report and all subsequent studies and position statements based on it is their inability to account for pre-SOCE levels of distress, which is a key component for disentangling distress attributable to a psychotherapeutic intervention and distress experienced by clients prior to ever engaging in therapy. Without this data, the actual degree of harm attributable to therapy is unknowable. This is a critical fact of basic research methodology, particularly when the population under study is known to have high levels of adverse childhood experiences. To cite only one example, non-heterosexual persons report much higher levels of childhood sexual abuse (CSA) than heterosexual persons (Friedman et al., 2011; Rothman et al., 2011: Xu & Zheng, 2015), and CSA has been linked to later suicidality (Bebbington, et al., 2009; Bedi et al., 2011; Eskin, Kaynak-Demir, & Demir, 2005). Hence, without pre-SOCE assessment of participants' suicidality, claims attributing frequent suicidal thoughts and behaviors to be the direct result of change-allowing talk therapies constitute empirically unfounded speculation.

33. To summarize, a proper conclusion regarding the 2009 APA Report and its progeny is that these reports and position statements cannot provide a scientifically sound basis for restricting the rights of individuals to engage in and therapists to provide change-allowing professional psychotherapy. Utilizing this research to evaluate the provision of change-allowing talk therapies makes no more sense than studying a sample of former marital therapy patients who have subsequently divorced to determine the effectiveness and harm of marital therapy in general.

B. Non-heterosexual Identities, Attractions, and Behaviors Are Subject to Change for Many People and Particularly Among Females and Youth.

34. Central to the notion that some individuals can and do report change on a continuum of change in their sexual orientation is the issue of *immutability*. The APA Task Force Report said one of the "key findings in the research" on which it based its conclusion was that sexual orientation does not change through life events (APA, 2009, pp. 63, 86). Were all same-sex

attractions and behaviors fixed and not subject to change, then sexual orientation would indeed be an enduring trait and SOCE would be a futile exercise, including among minors. However, there is solid data to suggest that same-sex attractions and behaviors are not fixed and are subject to varying degrees of change. As summarized by Ott et al. (2013), "Reported sexual identity, attraction, and behavior have been shown to change substantially across adolescence and young adulthood" (p. 466). Hu, Xu, and Tornello (2016) studied longitudinal data and observed, "In the LGB [lesbian, gay, and bisexual] population, the dominant pattern was change." Dickson, van Roode, Cameron, and Paul (2013) further asserted that, "People with changing sexual attractions may be reassured to know that these are common rather than atypical (p. 762). This viewpoint has long been maintained within scientific circles. Klein, Sepekoff, and Wolf (1985) decades earlier affirmed "...the importance of viewing sexual orientation as a process which often changes over time" and noted "...the simplicity and inadequacy of the labels heterosexual, bisexual, and homosexual in describing a person's sexual orientation" (p. 43).

i. Lack of Agreement Regarding What Constitutes Sexual Orientation.

35. Contrary to the conventional wisdom, there is substantial debate with scientific circles as to what constitutes sexual orientation, and this uncertainty extends to terms such as "sexual orientation change efforts." Sexual orientation may be said to comprise same-sex attractions, fantasies, and behaviors, but this is insufficient to guide change-allowing talk therapists in knowing clearly whether what they are discussing with a client could be considered as a *sexual orientation* change effort. That term is nebulous, and many scholars admit they have no precise means of distinguishing sexual orientation from same-sex sexuality, *i.e.*, same-sex behaviors and attractions that may not signify a same-sex orientation (Diamond, 2003). Relatedly, Savin-Williams (2016) described sexual orientation as being a continuum rather than discreet categories, which theoretically could mean that an isolated same-sex attraction among an otherwise completely heterosexual person might be considered as a separate sexual orientation.

36. Echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125). Finally, Diamond and Rosky (2016) acknowledged these problems when they indicated,

> ....it is important to note that sexual orientation is not easy to define or measure. This obviously poses a problem for research on the causes of sexual orientation, given that the first step in such research is to identify individuals with different sexual orientation. (p. 365).

One could rationally argue that this also poses a problem for the politics of SOCE ban legislation.

ii. Non-Heterosexuality Is Not a Fixed Trait.

37. The definitive study by Laumann, Gagnon et al. (1994), cited by the APA (2009) task force, involved several thousand American adults between the ages of 18 and 60. This report contains the most careful and extensive database ever obtained on the childhood experiences of

matched homosexual and heterosexual populations. One of the major findings of the Laumann, Gagnon et al. study, which even surprised the authors, was that homosexuality as a fixed trait scarcely seemed to exist (Laumann, Michael, and Gagnon, 1994). Sexual identity is not the least fixed at adolescence but continues to change over the course of life. For example, the authors report:

> ...this implies that almost 4 percent of the men have sex with another male before turning eighteen but not after. These men, who report same-gender sex only before they turned eighteen, not afterward, constitute 42 percent of the total number of men who report ever having a same-gender experience. (Laumann, Gagnon, et al., p. 296)

They also note that their findings comport well with other large-scale studies.

> [O]verall we find our results remarkably similar to those from other surveys of sexual behavior that have been conducted on national populations using probability sample methods. In particular two very large-scale surveys...one in France [20,055 adults] and one in Britian [18,876 persons]. (p. 297)

38. This data suggest that heterosexuality is normative even for those who at one point in the past reported a non-heterosexual sexual orientation. Sexual orientation stability appears to be greatest among those who identify as heterosexual (Savin-Williams, Joyner, & Rieger, 2012): "This limited empirical evidence based on four large-scale or nationally representative populations indicates that self-reports of sexual orientation are stable among heterosexual men and women, but less so among non-heterosexual individuals" (p. 104). Moch & Eiback (2010) found that heterosexuality was more stable than homosexuality or bisexuality over a 10-year period in middle aged adults. Nearly half of women with initial bi- or homosexual identity opted for a different label 10 years later. Diamond and Rosky summarize the matter well: "Given the consistency of these findings, it is no longer scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait" (p. 370).

39. Heterosexuality likely exerts a constant, normative pull throughout the life cycle upon everyone. While admittedly Laumann attributes this reality to American society, the same findings have been found in other societies where it has been studied. A simpler explanation might look to human physiology, including the physiology of the nervous system, which is overwhelmingly sexually dimorphic, i.e., heterosexual. Therefore, it is not surprising that the brain would self-organize behavior in large measure in harmony with its own physiological ecology, even if not in a completely deterministic fashion.

40. Whether measured by action, feeling, or identity, Laumann, Gagnon, et al.'s (1994) data concerning the prevalence of homosexuality before age 18 and after age 18 reveal that its instability over the course of life occurred largely in one direction—toward heterosexuality—and reflected significant decline in non-heterosexual identities. This evidence of spontaneous change with the progression of time among both males and females is hardly a picture of sexual orientation stasis in adolescence that Ordinance 2017-47 seems to assume. To be fair, we cannot tell from this

data how many, if any, of those reporting change pursued SOCE. However, the data do provide a developmental context for the plausibility that change-allowing talk therapies could aide some individuals (including minors) in modifying same-sex attractions and behavior. It appears that the most common natural course for a young person who develops a non-heterosexual sexual identity is for it to spontaneously disappear unless that process is discouraged or interfered with by extraneous factors. Conceivably, therapies disallowing the potential for change (e.g., "gay-affirmative") could be interfering with normal sexual development.

iii. Fluidity of Non-Heterosexual Sexual Attractions and Identity is Commonplace.

41. Diamond's longitudinal studies of women with non-heterosexual identities revealed that 67% reported changing their identities over a ten-year period of time (Diamond, 2005, 2008). Diamond noted that, "Hence, identity *change* is more common than identity *stability*, directly contrary to conventional wisdom" (italics in original, p. 13). While changes in same-sex physical and emotional attractions among these women were admittedly more modest, they nevertheless occurred to the point where the findings "...demonstrate considerable fluidity in bisexual, unlabeled, and lesbian women's attractions, behaviors, and identities and contribute to researcher's understanding of the complexity of sexual-minority development over the life span" (Diamond, 2008, p. 12).

42. Farr, Diamond, and Boker (2014) presented evidence for the existence of subtypes of non-heterosexual women, both in the intensity or degree of their same-sex attractions and in how these attractions change over time. She noted that these women appear more likely than men to specifically report the roles of circumstance, chance, and choice in their sexual identity and orientation, concluding that, "These results support the notion that some degree of plasticity may be a fundamental component of female same-sex sexuality" (p. 1487). Dickson et al. (2013) reviewed the relevant scientific literature and concluded, "These studies demonstrate that there is more change in sexual orientation than would be expected from repeated cross-sectional studies and change appears to be more common among women than men" (p. 754).

43. Clearly, change in sexual attractions and behaviors on a continuum of change would appear possible for many women and adolescent girls, leaving no rational reason to preclude professionally conducted change-allowing talk therapies as one option for minor girls experiencing unwanted same-sex attractions and behaviors, provided adequate assessment to insure voluntary and informed consent. Finally, echoing the earlier observation by Laumann, Gagnon et al. (1994), Diamond (2005) concluded that, "In light of such findings, one might argue for an end to sexual categorization altogether, at least within the realm of social scientific research" (p. 125).

44. Although the general scholarly consensus is that non-heterosexual women are more fluid in their sexual attractions and behaviors than are men, this may not be the case. As Diamond (2017) noted, "Female sexuality was once thought to be more fluid and plastic than men's, but recent research has begun to challenge this view" (p. 1184). This includes research on sexual orientation fluidity by Katz-Wise (2015) and Katz-Wise & Hyde (2015). These researchers studied a sample of young adults (18-26 years of age) who reported a same-gender sexual orientation. They discovered that 63% of the women and 50% of the men reported fluidity in their sexual

attractions, and of these individuals 48% of the women and 34% of the men also reported change in their sexual orientation identity. Of additional import for evaluating the legitimacy of Ordinance 2017-47, participants who reported fluidity indicated that their initial experience of change in sexual attractions occurred on average *before* the age of 18.

45. More recently, Diamond (2016) reviewed relevant studies and concluded,

> The other major conclusion that we can draw from these studies is that change in patterns of same-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented...between 25% and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon. (p. 253)

46. It is also noteworthy that the Katz-Wise studies reported sexually fluid participants were more likely than sexually non-fluid participants to believe that sexual orientation is changeable. Non-sexually fluid men were more likely than sexually fluid men to believe that sexuality is something an individual is born with, while men who reported experiencing sexual fluidity were more likely than men who did not report sexual fluidity to view sexuality as changeable and subject to environmental influences. These findings may help explain the overwhelming dominance of men who provide testimony and personal anecdotes in favor SOCE bans, suggesting that non-heterosexual men who have not experienced change may assume that this is the case for all non-heterosexuals and support laws that ban professional change-allowing talk therapies for even sexually fluid male youths who freely seek assistance with their pursuit of change.

iv. Change Among Transgendered/Transsexual Individuals.

47. Intriguing research among transgendered persons finds that these individuals often report a change in their sexual orientation (Auer, Fuss, Hohne, Stalla, & Sievers, 2014). These researchers found almost 21% of their sample of 115 transsexual participants reported experiencing a change in their sexual orientation. They noted that, "Transition [surgically from one sex to the other] was not directly involved in this change, since a significant number of participants reported a change in sexual orientation prior to first psychological counseling and prior to initiation of cross-sex hormone treatment. The participants provided diverse individual explanation models, revealing that personal history, social environment as well as autoerotic feelings may impact on a change in sexual orientation" (p. 11). They observed that these changes may even be affected by personal decision, quoting one participant as stating, "While some people think that gender identity is something you acquire or learn, I think this was rather true for my alleged sexual orientation" (p. 9). While this study may raise more questions than it ultimately answers, it further undercuts an understanding of sexual orientation as a stable self-construct that is unchangeable for all persons in all circumstances.

v. Change Not Limited to Sexual Behavior.

48. A New Zealand study by Dickson, Paul, and Herbison (2003) further questions the claim that change might affect same-sex *behavior* but *not* same-sex *attraction*. This study found large and dramatic drops in homosexual attraction that occurred spontaneously for both sexes, a finding underscored even more by its occurrence in a country with a relatively accepting attitude toward homosexuality. Interestingly, the results also indicated a slight but statistically significant net movement toward homosexuality and away from heterosexuality between the ages of 21 and 26, which suggests the influence of environment on sexual orientation, particularly for women. Specifically, it appears likely that the content of higher education in a politically liberal environment contributed to the upswing in homosexuality in this educated sample of twenty-somethings. This notion is further supported by the fact that this increase in homosexuality follows a much larger decrease that would have had to take place in the years prior to 21 in order to account for the above findings. Additionally, once the educational effect wears off, the expected decline in homosexual identification resumed. The authors conclude that their findings are consistent with a significant (but by no means exclusive) role for the social environment in the development and expression of sexual orientation.

49. More recently, similar findings were reported among a sample of 116 polyamorous and monoamorous individuals (Manley, Diamond, & van Anders, 2015). The authors suggest "the prevalence of attraction shifts contradicts notions of attraction as stable and partnering behaviors and sexual identities as more fluid. Attraction shifts were far more common than shifts in either sexual identity or partner gender" (p. 177).

vi. Change Particularly Evident for Youth and Bisexuals.

50. A large longitudinal study by Savin-Williams and Ream (2007) is also noteworthy as it focused on the stability of sexual orientation components for adolescents and young adults. Three waves of assessment began when participants were on average just under 16 years of age and concluded when participants were nearly 22 years old. The authors observed a similar decline in non-heterosexuality over the time of the study: "All attraction categories other than opposite-sex were associated with a lower likelihood of stability over time" (p. 389). For example, 16-year-olds who reported exclusive same-sex attractions or a bisexual pattern of attractions are approximately 25 times more likely to change toward heterosexuality at the age of 17 than those with exclusively opposite sex attractions are likely to move towards bisexual or exclusively same-sex attractions (Whitehead & Whitehead, 2010). Ninety-eight percent of 16 to 17-year-olds moved from homosexuality or bisexuality towards heterosexuality over the course of the study.

51. To be fair, such changes were more pronounced among bisexuals and women. But keep in mind that Ordinance 2017-47 does not discriminate in its prohibition between SOCE provided for exclusively same-sex attracted minors and those whose unwanted same-sex attractions are part of a bisexual attraction pattern. Nor does the bill's ban distinguish between boys and girls. Savin-Williams and Ream observed that, "The instability of same-sex attraction and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals" (p. 393). They acknowledged that developmental processes are involved even as they focused mostly on problems with measurement. The reality of such spontaneous changes in sexual orientation among teenagers

is not in accord with a bill whose defenders contend sexual orientation is a universally enduring trait. In fact, these data suggest it is irresponsible to legally prevent access to change-allowing talk therapies and only allow affirmation of same-sex feelings in adolescence on the grounds that the feelings are intrinsic, unchangeable, and therefore the individual can only be homosexual.

52. Ordinance 2017-47's intent for a blanket prohibition on SOCE for all minors with unwanted same-sex attractions and behaviors is akin to doing heart surgery with a chainsaw in its inability to address the complex realities of sexual orientation. For example, a study by Herek et al. (2010) reported that "only" 7% of gay men reported experiencing a small amount of choice about their sexual orientation and slightly more than 5% reported having a fair amount or great deal of choice. Lesbian women reported rates of choice at 15% and 16%, respectively. It is worth noting that these statistics, which are not inconsequentially small, do suggest that sexual orientation is not immutable for all people and again suggest the plausibility that modification of same-sex attractions and behaviors could occur in change-allowing talk therapies for some individuals who voluntarily desire and seek such change. Even more important, however, are the findings for bisexuals: 40% of bisexual males and 44% of bisexual females reported having a fair amount or great deal of choice in the development of their sexual orientation. This is in addition to 22% of male bisexuals and 15% of female bisexuals who reported having at least a small amount of choice about their sexual orientation. Other studies confirm the particular instability of a bisexual sexual orientation (Savin-Williams, Joyner, & Rieger, 2012). These numbers create a significantly different impression about the enduring nature of sexual orientation than the picture often painted by proponents of Ordinance 2017-47. At a minimum, such data suggest that proponents of the Ordinance would have done better to exclude bisexuality from the scope of this bill. If such a large minority of individuals (albeit mostly bisexuals) experience a self-determinative choice as being involved in the development of their sexual orientation, why would it not be conceivable that change-allowing talk therapies might augment this process for some individuals with unwanted same-sex attractions and behaviors?

vii. Identification of the Mostly Heterosexual Orientation.

53. Further evidence that Ordinance 2017-47 ignores distinctions in sexual orientation relevant to SOCE is the recent identification of the "mostly heterosexual" orientation. This orientation has been reported by 2-3% men and 10-16% of women over time and constituted a sexual orientation larger than all other non-heterosexual identities combined (Savin-Williams, Joyner, & Rieger, 2012). Moreover, it appears to be a highly unstable sexual orientation in comparison to other non-heterosxual identities. The reality of the "mostly heterosexual" orientation category has been additionally supported by recent physiological evidence in a sample of men (Savin-Williams, Rieger, & Rosenthal, 2013). This apparently viable and unique group of non-heterosexuals raises serious questions for the scope of Ordinance 2017-47; namely, are "mostly heterosexual" minors exempt from the law's ban on SOCE? The fact that the Ordinance is oblivious to such important nuances highlights the folly of politicians attempting to adjudicate the complex scientific matters surrounding change-allowing talk therapies at the behest of activists within and outside professional organizations.

54. All of the above evidence of fluidity and change in sexual orientation strongly suggests that change in the dimensions of sexual orientation does take place for some people (and likely more so for youth) and that this change is best conceptualized as occurring on a continuum

and not as an all-or-nothing experience. The experience of clinicians who engage in change-allowing talk therapies is that while some clients report complete change, and some indicate no change, many clients report achieving sustained, satisfying, and meaningful shifts in the direction and intensity of their sexual attractions, fantasy, and arousal as well as behavior and sexual orientation identity.

55. Descriptions of licensed therapists engaged in SOCE as trying to "cure" their clients of homosexuality are either ignorant or willfully slanderous of how these therapists conceptualize their care (see Alliance for Therapeutic Choice and Scientific Integrity (ATSCI), 2018). Licensed therapists who provide change-allowing care recognize that change of sexual orientation typically occurs on a continuum of change, and this is consistent with how change is understood to occur for most if not all other psychological and behavioral conditions addressed in psychotherapy.

viii. Genetics and Biology Are at Best Partial Explanations for Same-Sex Attractions

56. Moreover, such fluidity and change make clear that simple causative genetic or biological explanations are inappropriate. The later development of same-sex attractions and behaviors is not determined at birth and there is no convincing evidence that biology is determinative for many if not most individuals (Diamond & Rosky, 2016). The American Psychiatric Association has observed that, "...to date there are no replicated scientific studies supporting any specific biological etiology for homosexuality" (American Psychiatric Association, 2013). Peplau et al. (1999) earlier summarized, "To recap, more than 50 years of research has failed to demonstrate that biological factors are a major influence in the development of women's sexual orientation...Contrary to popular belief, scientists have not convincingly demonstrated that biology determines women's sexual orientation."

57. It is important to note in this regard that the APA's own stance on the biological origin of homosexuality has softened in recent years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way": "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality" (APA, 1998). But in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008a; emphases added).

Yet the APA has made minimal effort to publicize the change in its official position on such causation or to correct the accompanying popular misconception – often promoted by the media – that persons with same-sex attractions are simply "born that way" and "can't change." It is difficult not to perceive this as significant professional neglect.

58. The absence of genetic or biological determinism in sexual orientation is underscored and clarified by large scale studies of identical twins. These studies indicate that if one twin sibling has a non-heterosexual orientation the other sibling shares this orientation only about 11% of the time with upper estimates at 24% (v, Dunne, & Martin, 2000; Bearman & Brueckner, 2002; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010; Xu, Norton, & Rahman, 2019). If factors in common like genetics or conditions in the womb overwhelmingly caused same-sex attractions, then identical twins would *always* be identical for same-sex attraction. These studies instead suggest that the largest influence in the development of same-sex attractions are environmental factors that affect one twin sibling but not the other, such as unique events or idiosyncratic personal responses. Xu and colleagues (2019) concluded, "Thus, most of the differences between people in their sexual orientation are due to environmental factors (often nonshared) pointing to multiple etiology" (p. 1).

59. Similarly, heritability of sexual orientation is approximately .32, indicating that 32% of the population variability in sexual orientation is due to genetic factors (Diamond & Rosky, 2016). Heritability is the variability between persons in a population, not an indicator of the relative contributions of genetic and environmental influences within individuals. Diamond and Rosky put this in perspective by stating, "...it is helpful to note that higher estimations of heritability (ranging from .4 to .6) have been found for a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having low back pain, and feeling body dissatisfaction" (p. 366). Given these statistics, it is curious that, for example, smoking is a behavior considered subject to change, while proponents of SOCE bans often maintain sexual orientation is an immutable behavioral characteristic.

60. Causatively, then, sexual orientation is by no means comparable to a characteristic such as race or biological sex which are thoroughly immutable. Thus, while same-sex attractions may not be experienced as chosen, it is reasonable to hold that they can be subject to conscious choices such as those which might be facilitated in change-allowing therapies. Same-sex attractions and behaviors are not strictly or primarily determined by biology or genetics and are naturalistically subject to significant change, particularly in youth and early adulthood. This should raise serious questions about the legitimacy of Ordinance 2017-47's portrayal of same-sex attractions and behaviors as static traits only to be embraced by those minors who might otherwise desire the option of exploring change.

C. The Reality of Sexual Fluidity Underscores the Impropriety of Prohibiting Change-Allowing Talk Therapies.

61. Although no reputable scholar can now deny that the components of sexual orientation evidence significant fluidity for many non-heterosexual persons, the adamant contention of SOCE ban supporters is that such naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-allowing talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-allowing talk therapies often address these exact influences with their clients. For example, same-sex attraction fluidity is known to sometimes occur in response to changes in emotional and romantic attachments. Hu et al. (2016) reported, "The results suggested that people who report same-sex attractions with no

relationship or an opposite sex partner were more likely to shift their same-sex attractions than those who reported a same-sex relationship" (p. 658). In evaluating neurobiological research, Diamond and Rosky (2016) noted that "...one possibility [for shifts in sexual attractions] is that the formation of emotional attachments may facilitate unexpected changes in sexual desire" (p. 370). Similarly, Manely et al. (2015) assert, "...research on sexual fluidity suggest that, for some people, relationships may in fact influence sexual orientation, meaning that emotionally intimate relationships may lead to sexual attractions toward a gender to which one had not previously been attracted" (p. 168). Change-allowing talk therapy may address exactly such influences, assisting clients with their relationships in ways that for some may facilitate genuine shifting in sexual attractions and behaviors.

62. At this point in time there are only political as opposed to theoretical obstacles to acknowledging some people can be their own agents of change in a process assisted by change-allowing talk therapy, including minors. Therapists who engage in this work report such experiences with some regularity, though certainly not for all clients. Research in this arena is of course very desirable, but hard to come by, for many reasons. Demands for such research seem to ignore the fact that (1) it is quite difficult to study a therapy process that is being made illegal, (2) funding sources for such research typically have vested interests in the outcomes as do the researchers, (3) obtaining findings favorable in any way to change-allowing talk therapies will likely result in the marginalization and professional ostracization of the researcher (Wood, 2013). It appears there will need to be a change, or at least a significant shifting, in the ideologically unbalanced professional culture of psychology before we can undo the current politically required foreclosure on the science of talk therapy-assisted fluidity in same-sex attractions and behaviors. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148).

D. Professional SOCE Bans Target Speech, Not Aversive Practices.

63. There is now clear evidence from state legislative proceedings that the intent of bans such as Ordinance 2017-47 is to stifle therapist speech and not certain aversive practices. Across the country where ban legislation for minors has been debated, politicians are hearing testimonials that directly or by implication associate SOCE provided by licensed therapists with painful aversive techniques such as shocking genitals, chemically induced vomiting, taking ice baths, and the like. This caricature of contemporary change-allowing talk therapies as promoting such child abuse is both disingenuous and slanderous, as was revealed in the legislative process surrounding proposed therapy bans in the states of Washington in 2015 and Utah in 2019. In both instances, amendments were made in committee that would have preserved a legal prohibition on the harmful aversive techniques but would have specially protected therapist speech. In the Utah example, the amendment would even have penalized guarantees of "a complete and permanent reversal in the patient or client's sexual orientation."

64. Nevertheless, despite the prospect of bipartisan support for these bills, proponents pulled the legislation, complaining they did not go far enough despite their targeting of the same aversive practices that were prominently mentioned as a basis for these bans (Backholm, 2015; "Watered down anti-conversion therapy bill," 2019). Particularly telling were the comments by

University of Utah College of Law professor Clifford Rosky, who developed the original ban bill in Utah, as reported in the local gay press:

> "Licensed therapists haven't been doing electric shock therapy and adversant [sic] practices in decades," Rosky continued. What they do these days, he said was talk therapy. "As we know, words are just as damaging to children."

Clearly then, proponents of change-allowing talk therapy bans have known all along that allowing abusive aversive practices to be associated with contemporary professional SOCE is a fundamentally dishonest political maneuver. Politicians and judges need to hear from ban proponents examples of what specific words change-allowing talk therapy practitioners say to minors that creates damage on a par with electroshocking their genitals.

E. State Regulatory Boards Already Are Equipped to Discipline Abusive Practitioners.

65. If any minors in the care of licensed therapists have been subjected to any of the aversive practices often declared by ban proponents, it is incomprehensible that some of these clinicians would not have been brought before their state licensing boards for such egregiously unethical child abuse. This raises a question for proponents of bans such as Ordinance 2017-47: Are these bans a solution to a problem that does not exist for minor clients of licensed therapists?

66. State regulatory boards exist and are funded for the purposes of addressing exactly the kinds of unacceptable aversive practices ban proponents claim is occurring with some licensed SOCE providers. It is imperative any concerns along these lines be addressed by a state regulatory body of other therapists who have the training and expertise to ensure ethical counseling practices. Such a body will understand the nuances of psychotherapeutic work and hence be in a position to accurately determine genuine malpractice. Given that mental health professionals who engage in change-allowing therapies have expended great amounts of time and money on their education and careers and have much to lose, genuine justice demands any questions about their therapy-related speech be adjudicated by their professional peers in state regulatory agencies. Untrained politicians and city officials are by no means qualified to police professional practice issues, including the goals and content of therapy offered by licensed mental health practitioners.

IV. Concluding Statements

67. As this declaration has documented, there is reasonable evidence to suggest that professional associations such as the APA do not approach the SOCE literature in an objective manner but rather with an eye to their advocacy interests. This is seen in the purposeful exclusion of conservative and SOCE sympathetic psychologists from the APA task force as well as the clearly uneven application of methodological standards in assessing evidence of SOCE efficacy and harm. As the task force noted, the prevalence of success and harm from SOCE cannot be determined at present, and recent SOCE research does not advance the field sufficiently to provide a scientific basis for ban legislation. Anecdotal accounts of harm, which are a focal point of attention by supporters of bans such as Ordinance 2017-47, cannot serve as a basis for the blanket prohibition of an entire form of psychological care, however meaningful they may be on a personal

level. It is negligent if not fraudulent that APA and other professional organizations accept such unverified claims that experiences of SOCE were "harmful" while dismissing much better documented claims that experiences of SOCE were "beneficial," and were not "harmful" (Phelan, Whitehead, & Sutton, 2009). Indeed, it is not difficult to find counterbalancing anecdotal accounts of benefit from change-allowing talk therapies (see http://voicesofchange.net; https://changedmovement.com/). Furthermore, as observed earlier, accounts of harm cannot tell us if the prevalence of reported harm from change-allowing therapies is any greater than that from psychotherapy in general.

68. The normative occurrence of spontaneous change in sexual orientation among youth and adults and the nontrivial degree of choice reported by some in the development of sexual orientation further bring into question the appropriateness of Ordinance 2017-47. Sexual orientation is not a stable and enduring trait among youth, and this lends plausibility to the potential for professionally conducted SOCE to assist in change in unwanted same-sex attraction and behaviors with some minors. Granted, high quality research is needed to confirm clinical reports of change. However, it should be mentioned in this regard that Ordinance 2017-47 would make further research on change-allowing talk therapies with minors impossible in Tampa, despite the APA task force's clear mandate that such research be conducted (APA, 2009).

69. Any purported concerns of harm anecdotally attributed to SOCE practice with minors can most appropriately be remedied by the application of ethical principles of practice, including informed consent, and addressed through the existing oversight functions of state regulatory boards and state mental health associations. Ordinance 2017-47 is a legislative overreach that takes an overly broad and absolute approach to SOCE harm and success despite evidence suggesting age, gender, and non-heterosexual sexual orientation differences in the experience and degree of change in sexual orientation. In particular, it is fair to ask whether bisexual and mostly heterosexual youth are well served by Ordinance 2017-47, a distinction this law does not make.

70. Proponents of Ordinance 2017-47 reason that because homosexuality is no longer considered to be a disorder, providing change-allowing talk therapies to minors with unwanted same-sex attractions and behaviors is at best unnecessary and at worst unethical. However, this reasoning betrays a profound misrepresentation of the scope of psychotherapeutic practice, as there are numerous examples of professionally sanctioned targets of treatment that are not considered to be disorders. These include relationship distress, normal grief reactions, and unplanned pregnancy. Clients often pursue psychological care for such difficulties due to deeply held religious and moral beliefs (i.e., that divorce or abortion are wrong) and may experience significant emotional distress in addressing these issues. In this context, the selective attention Ordinance 2017-47 gives to SOCE again hints at political advocacy rather than science as a primary inspiration for this law.

71. Clients will not be well served if change-allowing talk therapy with minors is judged *never* to be an appropriate modality for psychological care. Neither the courts nor the professional associations should be substituting their judgment for that of a 17-year old who is calculating a cost-benefit analysis in deciding whether to undergo change-allowing talk therapy, understanding through informed consent that fluidity in unwanted same-sex attractions may or may not occur. The APA is quite clear that it supports the competence of a 17-year old girl to give

consent to an abortion. Why does the 17-year old lose competence when it comes to change-allowing talk therapies?

72. Similarly, the APA is on record as supporting the availability of sexual reassignment surgery for adolescents (APA, 2008b) and Ordinance 2017-47 implicitly protects this option. Is it reasonable that 17-year olds who experience themselves to be the wrong biological sex be allowed to surgically remove breasts and alter genitalia while others with unwanted same-sex attractions and behavior be prohibited from even *talking* to a licensed therapist in a manner that could be construed as promoting the pursuit of change? This question is especially relevant in light of high quality longitudinal research that suggests sexual reassignment surgery does not remedy high rates of morbidity and mortality among transgendered individuals (Dhejne, et al., 2011).

73. The task force Report (APA, 2009), and the mental health associations that subsequently relied on it for their resolutions on SOCE, including those cited in the Ordinance, provide one viewpoint into research and reasoning which must be considered incomplete and therefore not definitive enough to justify a complete ban on change-allowing therapies with minors. Currently, there is a lack of sociopolitical diversity within mental health associations (Duarte et al., 2015; Redding, 2001), which has an inhibitory influence on the production of scholarship in controversial areas such as change-allowing talk therapies that might run counter to preferred worldviews and advocacy interests. An authentically scientific approach to a contentious subject must proceed in a different direction in order to give confidence that the relevant database is a sufficiently complete one on which to base public policy. As Haidt (2012) observed, genuine diversity of perspective is absolutely necessary:

> "In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons...This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board)" (p. 90).

Such diversity is precisely what is lacking currently in professional mental health organizations and their associated scientific communities as regards the study of contested social issues related to sexual orientation, including SOCE (Duarte et al., 2015; Wright & Cummings, 2005). It would hard to understand, for example, how the leadership of the National Association of Social Workers could endorse a total of 542 candidates in federal elections between 2014 and 2018—all of whom were affiliated with the Democratic Party (NASW, 2018). These figures undoubtedly represent a "statistically impossible lack of diversity" (Tierney, 2011).

74. The APA lost 10% of its members between 2008 and 2013 and now represents less than 44% of psychologists in America (Robiner, Fossum, & Hong, 2015). The American Medical Association now represents less than 20% of physicians in the country. These downward trends have in part come about due to these associations' taking left-of-center positions on several social and policy issues, alienating conservative members and leading many of them to disaffiliate. It is evident from these kinds of statistics that, when it comes to socially contentious issues such as

change-allowing talk therapies, the mental health and medical associations likely do not speak for many of those professionals who practice in their respective fields.

75. To repeat a final time, a truly scientific response to the concerns of the sponsors of Ordinance 2017-47 would be to encourage bipartisan research into SOCE with minors that could provide sound data to answer questions of harm and efficacy that currently are only primitively understood. Change-allowing talk therapy practitioners take seriously their responsibility to do no harm and would assuredly embrace such an opportunity (Jones, et al., 2010). Were proponents of Ordinance 2017-47 not playing a winner-take-all approach to the issue of professional SOCE, there would undoubtedly be substantial ground both sides could agree upon that would address concerns regarding alleged harms and reported benefits from change-allowing talk therapies. Unfortunately, the approach taken by Ordinance 2017-47 sponsors represented only one (political and legislative) perspective on how to best address the challenges that come with the psychological care of unwanted same-sex attractions and behaviors. It is therefore a scientifically premature, and therefore unjust, violation of the rights of current and potential change-allowing talk therapy consumers, their parents, and their therapists and should not be allowed to stand.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this May 6, 2019.

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I. Education.

B. A. University of Oregon (Honors college), Eugene, Oregon, 1980 (psychology).
M.A. Fuller Theological Seminary, Pasadena, California, 1984 (theological studies).
Ph.D. Fuller Graduate School of Psychology, Pasadena, California, 1986 (clinical psychology - APA approved program).

II. Honors.

Phi Beta Kappa, Alpha of Oregon, 1980.
Exemplary Paper in Humility Theology Award, John Templeton Foundation, 1998.

III. Professional Experiences.

9/85 - 8/ 86	Clinical psychology intern, Camarillo State Hospital, Camarillo, California (APA approved internship).
11/86 - 5/88	Postdoctoral intern, Link Care Center, Fresno, California.
5/88 - Present	Licensed clinical psychologist, Link Care Center, Fresno, California.
11/94 - 6/96	Assistant Clinical Director, Link Care Center, Fresno, California.
7/96 - 12/99	Clinical Director, Link Care Center, Fresno, California.
1/01 – Present	Clinical Faculty, Fresno Pacific University
1/05 – Present	Director of Research, Link Care Center, Fresno, California

IV. Professional Affiliations.

1/84 - Present	Member, American Psychological Association.
1/86 - Present	Member, Christian Association for Psychological Studies (CAPS).
6/90 - 6/93	Member, board of directors, CAPS-Western region.
6/01 – 5/05	President-Elect, President, and Past-President, CAPS-Western Region
1/92 - Present	Member, International Society for the Study of Dissociation.
7/99 – Present	Member, Alliance for Therapeutic Choice and Scientific Integrity (Alliance)
1/11 – 12/17	President-Elect, President, and Past President, Alliance
1/11 - Present	Member, National Association of Social Workers.

V. Selected Publications.

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