

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, individually )  
and on behalf of his patients, )  
DAVID H. PICKUP, LMFT, individually )  
and on behalf of his patients, and ) Case No. 8:17-cv-2896-T-02AAS  
SOLI DEO GLORIA INTERNATIONAL, )  
INC. d/b/a NEW HEARTS OUTREACH )  
TAMPA BAY, individually and on behalf of )  
its members, constituents and clients, )  
 )  
Plaintiffs, )  
 )  
v. )  
 )  
CITY OF TAMPA, FLORIDA, )  
 )  
Defendant. )  
 )

---

**PLAINTIFFS' STATEMENT OF UNDISPUTED FACTS  
IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

Plaintiffs ROBERT L. VAZZO, LMFT, individually and on behalf of his patients, and SOLI DEO GLORIA INTERNATIONAL, INC. d/b/a NEW HEARTS OUTREACH TAMPA BAY, individually and on behalf of its members, constituents, and clients, pursuant to Rule 56, Fed. R. Civ. P., Local Rule 3.01, and the Court's Case Management and Scheduling Order (D.183), file this statement of the material facts of record as to which there is no genuine issue to be tried, in support of Plaintiffs' Motion for Summary Judgment filed contemporaneously herewith.

**TABLE OF CONTENTS**

TABLE OF CONTENTS..... i

TABLE OF REFERENCES TO THE RECORD ..... ii

UNDISPUTED FACTS .....1

A. City of Tampa Ordinance 2017-47. ....1

B. Plaintiff Robert L. Vazzo, LMFT. ....1

C. Tampa Interprets the Ordinance to Prohibit *Speech*. ....3

D. There Is No Legislative or Other Record of Complaints of Harm from SOCE in Tampa. ....5

E. The Ordinance is Not Supported by Empirical Evidence of Harm from “Conversion Therapy.” .....5

1. Neither the City nor the APA Report Can Quantify Harm from “Conversion Therapy.” .....5

2. The APA Report Discloses Anecdotal Evidence of Benefits from SOCE at Least Equivalent to Anecdotal Evidence of Harm, and More Benefits Perceived by Religious Individuals. ....7

3. The APA Report Excludes Gender Identity Change Efforts, Which Similarly Lack Empirical Research. ....9

4. The APA Report Commends a Client-Directed Approach to Therapy for Clients with Unwanted Same-Sex Attractions, Commends More Research on Voluntary SOCE, and Condemns Only Coercive Therapies. ....11

5. The APA Report Specifically Calls for Therapists to Respect and Consider the Religious Values of Individuals Desiring Therapy. ....16

6. No Study Since the 2009 APA Report Updates or Changes the Empirical Record. ....17

F. Tampa Did Not Tailor the Ordinance to Any Identified Interest or the Realities of SOCE Counseling. ....19

G. Tampa Code Officials Are Not Qualified or Equipped to Enforce the Ordinance’s Therapy Ban. ....19

CERTIFICATE OF SERVICE .....21

**TABLE OF REFERENCES TO THE RECORD**

The following record materials are cited herein by the indicated parenthetical references:

<b>Dkt.</b>	<b>Document</b>
24-1 PageID 343–350	City of Tampa Ordinance 2017-47 (“ <b>Ordinance</b> ”)
24-4 Page ID 509–527	AACAP Statement (“ <b>AACAP Statement</b> ”)
24-4 PageID 535 to 24-6 PageID 611	Substance Abuse and Mental Health Services Administration (SAMHSA), <i>Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth</i> (2015) (“ <b>SAMHSA Report</b> ”)
78	First Amended Verified Complaint (“ <b>FAVC</b> ”)
133-1	Deposition of Sal Ruggiero (“ <b>Ruggiero</b> ”)
133-2	Deposition of Councilman Guido Maniscalco (“ <b>Maniscalco</b> ”)
133-3	Deposition of Jerrod Simpson, Esquire (“ <b>Simpson</b> ”)
134-17	2009 Report of American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (“ <b>APA Report</b> ”)
135-1	<i>Guidelines for Psychological Practice with Transgender and Gender Nonconforming People</i> , 70(9) Am. Psychologist 832 (2015), <a href="https://www.apa.org/practice/guidelines/transgender.pdf">https://www.apa.org/practice/guidelines/transgender.pdf</a> (“ <b>APA TGNC Guidelines</b> ”)
138	Transcript of Preliminary Injunction Hearing (“ <b>PI Hearing</b> ”)
140-1	Plaintiffs’ Preliminary Injunction Hearing Slides, Presentation of Horatio G. Mihet (“ <b>140-1 Slides</b> ”)
140-2	Plaintiffs’ Preliminary Injunction Hearing Slides, Presentation of Roger K. Gannam (“ <b>140-2 Slides</b> ”)
149	Report & Recommendation on Plaintiffs’ Motion for Preliminary Injunction (“ <b>MPI R&amp;R</b> ”)
192-1	Deposition of Judith M. Glassgold, Psy.D (“ <b>Glassgold</b> ”)
192-2	Deposition of Norman Spack, M.D. (“ <b>Spack</b> ”)

**UNDISPUTED FACTS**

**A. City of Tampa Ordinance 2017-47.**

1. City of Tampa Ordinance 2017-47 took effect on April 10, 2017. (FAVC ¶¶ 24–26.) Section 5 of the ordinance states that “[i]t shall be unlawful for any Provider to practice conversion therapy efforts on any individual who is a minor regardless of whether the Provider receives monetary compensation in exchange for such services.” (FAVC ¶ 27). Section 4 defines “conversion therapy efforts” (“SOCE counseling”) as:

any counseling, practice, or treatment performed with the goal of changing an individual’s sexual orientation or gender identity, including, but not limited to, efforts to change behaviors, gender identity, or gender expression, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender or sex. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person’s coping, social support, and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change sexual orientation or gender identity.

(FAVC ¶ 28). Each violation of the ordinance constitutes a separate offense and carries a \$1,000.00 fine for the first offense and \$2,000.00 for each and every subsequent violation. (FAVC ¶ 30.)

**B. Plaintiff Robert L. Vazzo, LMFT.**

2. Plaintiff, Robert L. Vazzo, LMFT, is a marriage and family therapist and is licensed to practice mental health counseling in California, Florida, Nevada, and Ohio. (FAVC ¶ 100.) Vazzo specializes in SOCE (sexual orientation change efforts) counseling, including in the areas of unwanted same-sex attraction (SSA). (FAVC ¶ 102.) His practice includes approximately 17–25 clients each week, and ten percent of those clients are minors seeking SOCE counseling. (*Id.*)

3. Vazzo helps clients with their unwanted same-sex attractions, behaviors, and identity by talking with them about root causes, about gender roles and identities, and about their

associated anxieties and confusion. (FAVC ¶ 62.) Speech is the only tool that Vazzo uses in his counseling with minors seeking to reduce or eliminate their unwanted SSA, behaviors, or identity. (FAVC ¶ 63.) The only thing that happens in their counseling sessions is speech. (*Id.*) Vazzo talks with his clients about the clients' goals, objectives, religious beliefs, desires, and identity. (*Id.*) Vazzo does not engage in aversive techniques, nor is he aware of any practitioner who engages in such techniques in providing SOCE counseling to minors. (FAVC ¶ 61.)

4. Vazzo does not begin counseling with any predetermined goals other than those that the clients themselves identify and set. (FAVC ¶ 64.) Vazzo employs speech to help clients understand and identify their anxieties or confusion regarding their attractions or identities, and then to help each client formulate the method of counseling that will most benefit the client. (FAVC ¶ 65.) Vazzo's counseling often focuses on helping parents heal wounds or frustrations with their child and to work on loving and accepting their child despite any challenges that arise from the child's unwanted same-sex attractions, behaviors, or identity. (FAVC ¶ 66.)

5. Many of Vazzo's clients who desire SOCE counseling profess to be Christians with a sincerely held religious belief that homosexuality is harmful and destructive and therefore seek SOCE counseling to live a lifestyle in congruence with their faith and to conform their identities, attractions, and behaviors to their sincerely held religious beliefs. (FAVC ¶ 104.) Vazzo has never received any complaint or report of harm from any of his clients seeking and receiving SOCE counseling, including the many minors that he has counseled. (FAVC ¶ 105.) In fact, all of Vazzo's clients who have engaged in SOCE counseling for at least one year have experienced some degree of positive change with respect to their unwanted SSA. (*Id.*) **Vazzo does not coerce any client to engage in SOCE counseling and would never engage in any counseling unless the client desires such counseling and voluntarily consents to it.** (FAVC ¶ 106.)

6. Vazzo has had numerous clients in Florida, provides counseling to clients in Florida, and constantly receives inquiries from all over the State concerning SOCE counseling. (FAVC ¶ 108.) Vazzo has been contacted by individuals in Tampa who desire to engage in SOCE counseling with Vazzo, including a fifteen-year-old minor client seeking SOCE counseling from Vazzo. (FAVC ¶¶ 109-110.) Vazzo’s client desires to receive SOCE counseling from a licensed professional counselor with expertise in this particular area. (*Id.*). Vazzo’s client struggles with unwanted SSA and desires to engage in SOCE counseling with Vazzo to reduce or eliminate the client’s unwanted SSA. (FAVC ¶ 111.) Vazzo is prohibited from providing SOCE counseling because of the ordinance, and his client is prohibited from receiving such counseling from a licensed professional. (FAVC ¶ 112.)

7. Vazzo and New Hearts also assert as undisputed facts the verified allegations at FAVC 67–71, 88, 90, 93–97, 126, 130, 131, 133, 134–143, 151–153, 155–159, 164.<sup>1</sup>

**C. Tampa Interprets the Ordinance to Prohibit *Speech*.**

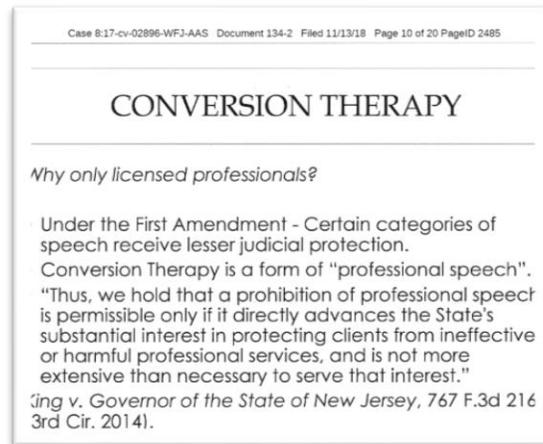
8. The City admitted its intention to censor **speech** through the ordinance, both in the text of the ordinance itself, and in the post-enactment enforcement training materials prepared by the City’s attorney overseeing enforcement. (MPI R&R 25–26 (citing Ordinance PageID 347, Pls.’ Dep. Ex. 2, Dkt. 134-2, at 10.) First, the plain language of the ordinance targets counselors’ speech:

12	WHEREAS, At least two federal circuit courts of appeal have upheld bans
13	on conversion therapy. <sup>15</sup> Both courts found that bans on conversion therapy did not
14	violate free speech rights; nor did such bans run afoul of the Free Exercise Clause;
15	nor were such bans vague or impermissibly overbroad. Further the courts found that
16	counseling is professional speech, subject to a lower level of judicial scrutiny because
17	the government has a substantial interest in protecting citizens from ineffective or
18	harmful professional practices: and

---

<sup>1</sup> The City did not conduct discovery or otherwise adduce record facts to contradict the verified allegations of Plaintiffs’ First Amended Verified Complaint (Dkt. 78).

(Ordinance PageID 347<sup>2</sup>.) Second, in the City’s post-enactment training of its code officials responsible for enforcing the ordinance, the City’s attorney responsible for enforcement confirmed the City’s intent and interpretation of the ordinance to censor “professional speech”:



(Pls.’ Dep. Ex. 2, Dkt. 134-2, at 10; Simpson 95:24–96:13; 140-1 Slides 16; PI Hr’g 32:7–34:16.)

9. The City interprets the ordinance to prohibit a counselor’s adopting or affirming a client’s goal to change sexual orientation or gender identity, even where the counselor did not initiate or predetermine the goal. (Simpson 66:8–21; 140-1 Slides 2; PI Hr’g 15:1–16:12.) The City interprets the ordinance to prohibit a therapist’s encouraging a ten-year-old, biological boy, who has expressed a female gender identity, to embrace or align with his biological male gender role or identity. (Ruggiero 95:2–17; 140-1 Slides 20; PI Hr’g 52:13–65:4.) The City interprets the ordinance to punish a counselor’s viewpoint that affirms a client’s goal to change sexual orientation or gender identity. (Simpson 66:8–21; 140-1 Slides 2; PI Hr’g 15:1–16:12.)

---

<sup>2</sup> The “two federal circuit courts” which “found that counseling is professional speech, subject to a lower level of judicial scrutiny” according to this recital are *King v. Governor of New Jersey*, 767 F.3d 216, 232 (3d Cir. 2014), and *Pickup v. Brown*, 740 F.3d 1208, 1227–1229 (9th Cir. 2014). (Dkt. 24-1 at PageID 347, 347 n.15). On this point, both of the cases subsequently were abrogated by the Supreme Court in *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371–72 (2018).

**D. There Is No Legislative or Other Record of Complaints of Harm from SOCE in Tampa.**

10. The City received no complaints of harm from “conversion therapy” or SOCE provided in Tampa. (MPI R&R 35 (citing Def.’s Resps. & Objs. Pls.’ Disc. Reqs., Dkt. 132-1, at 8); *see also* 140-1 Slides 18; PI Hr’g 45:10–48:9.) In proposing and enacting the ordinance, **the City made no effort to investigate or otherwise determine whether any such complaints existed.** (Maniscalco 41:3–22; 140-1 Slides 19; PI Hr’g 45:10–48:9.) Furthermore, Vazzo has never received a complaint or report of harm from any client receiving SOCE counseling. (FAVC ¶ 105.)

**E. The Ordinance is Not Supported by Empirical Evidence of Harm from “Conversion Therapy.”<sup>3</sup>**

**1. Neither the City nor the APA Report Can Quantify Harm from “Conversion Therapy.”**

11. The ordinance itself claims justification in “overwhelming research,” which refers exclusively to fourteen sources appearing in the ordinance’s recitals. (Ordinance PageID 344–47.) The sources cited (collectively, the “Sources”) comprise various reports, statements, and position papers, including the 2009 Report of American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA Report). (Ordinance PageID 344–45, 345 n.3.) Some of the other Sources cite to the APA Report, but none of the other Sources updates or contradicts the conclusions in the APA Report. (*See, e.g.*, SAMHSA Report PageID 568 (“**No new studies have been published that would change the conclusions reached in the APA Taskforce’s 2009 review.**” (emphasis added)), PageID 569 (“**[N]o research demonstrating**

---

<sup>3</sup> PI Hr’g 51:4–77:25.

**the harms of conversion therapy with gender minority youth has been published . . . .”**

(emphasis added)); *see also* PI Hr’g 65:5–72:12; 140-1 Slides 34–39.)

12. The APA Report discloses up front, and repeatedly throughout, that there is no empirical or other research supporting **any conclusions** regarding either efficacy **or harm** from SOCE,<sup>4</sup> especially in children and adolescents. (APA Rep. 3 (“[T]he recent SOCE research **cannot provide conclusions** regarding efficacy or safety . . . .”), 7 (“The research on SOCE **has not adequately assessed** efficacy and safety.”), 37 (“These [recent] studies all use designs that **do not permit cause-and-effect attributions to be made.**”), 42 (“[T]he recent studies **do not provide valid causal evidence** of the efficacy of SOCE **or of its harm . . . .**”), 42 (“[T]he nature of these studies **precludes causal attributions** for harm or benefit to SOCE . . . .”), 42 (“We conclude that there is a **dearth of scientifically sound research** on the safety of SOCE. . . . Thus, **we cannot conclude how likely it is that harm will occur** from SOCE.”), 72 (“**There is a lack of published research on SOCE among children.**”), 73 (“**We found no empirical research on adolescents who request SOCE . . . .**”), 90 (“**We concluded that research on SOCE . . . has not answered**

---

<sup>4</sup> The APA Report does not use the term “conversion therapy.” Rather, the APA Report uses “the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.” (APA Rep. 12 n.5.) The Task force chose the term SOCE over terms like “conversion therapy” because SOCE is more descriptive and specific, while “conversion therapy” is a lay term subject to misinterpretation and unintended connotations. (Glassgold 71:12–25.) The SOCE term was intended to refer to “efforts that have the a priori goal, prior to even meeting the client, that homosexuality should be changed or that sexual orientation should be changed,” and practices that “attempted, a priori to seeing the client and listening to the client’s concerns, that the client needed to eliminate or eradicate those feelings.” (Glassgold 58:20–60:1.)

**basic questions of whether it is safe or effective and for whom.”**), 91 (“**[S]exual orientation issues in children are virtually unexamined.**”) (all emphases added.)

13. The City’s expert Judith M. Glassgold, Psy.D, was the Chair of the APA Task Force (the “Task Force”) that authored the 2009 APA Report. (Glassgold 48:18–49:4.) The APA has not withdrawn or updated any part of the 2009 APA Report, and there is no part of it that Dr. Glassgold would no longer endorse. (Glassgold 95:24–96:25.)

14. The Task Force did not attempt to quantify the prevalence or likelihood of harm from SOCE as compared to psychotherapy in general because the research did not allow any such quantification. (Glassgold 104:25–111:24.) The City cannot in any way quantify the purported risk of harm it claims to be posed by “conversion therapy” or SOCE. (Maniscalco 110:5–112:11 (“**No, nobody knows.**”(emphasis added)); PI Hr’g 75:9–77:25.) Neither can the City’s other expert, Norman Spack, M.D., quantify an increased risk of suicidality, depression, or any other poor mental health outcome from “conversion therapy” as compared to psychotherapy in general. (Spack 130:7–131:11.)

**2. The APA Report Discloses Anecdotal Evidence of Benefits from SOCE at Least Equivalent to Anecdotal Evidence of Harm, and More Benefits Perceived by Religious Individuals.**

15. Given the lack of empirical research on the outcomes of SOCE, the Task Force looked to participants’ perceptions of SOCE, “in order to examine what may be perceived as being helpful or detrimental by such individuals, **distinct from a scientific evaluation of the efficacy or harm . . . .**” (APA Rep. 49 (emphasis added).) The review did not show evidence of one outcome over the other. “[S]ome recent studies document that there are people who perceive that they have been harmed through SOCE, just as other recent studies document that there are people who perceive that they have benefited from it.” (APA Rep. 42 (citations omitted).)

16. The Task Force found several reported benefits of SOCE perceived by participants: “(a) a place to discuss their conflicts; (b) cognitive frameworks that **permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem**; (c) social support and role models; and (d) **strategies for living consistently with their religious faith and community.**” (APA Rep. 49 (emphasis added) (citations omitted).) “Participants described the social support aspects of SOCE positively.” (*Id.*)

17. The Task Force also observed that perceptions of harm may correlate specifically to “aversion techniques.” (APA Rep. 41 (“[S]tudies provide some suggestion that harm can occur from **aversive** efforts to change sexual orientation.” (emphasis added).)) To illustrate, the Report gives some examples of aversion treatments:

Behavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts. Other examples of aversive behavioral treatments included . . . shame aversion . . . .

(APA Rep. 22.)

18. The Task Force also found that individuals’ religious beliefs shape their experiences and outcomes:

[P]eople whose motivation to change was strongly influenced by their Christian beliefs and convictions were **more likely to perceive themselves as having a heterosexual sexual orientation after their efforts.** [T]hose who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. **Some . . . concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions.**

(APA Rep. 50 (emphasis added) (citations omitted).) “The participants had multiple endpoints, including LGB identity, ‘ex-gay’ identity, no sexual orientation identity, and a unique self-identity.” (*Id.*) “Further, the findings suggest that **some participants may have reconceptualized their sexual orientation identity as heterosexual . . . .**” (*Id.* at 50 (bold emphasis added).)

**3. The APA Report Excludes Gender Identity Change Efforts, Which Similarly Lack Empirical Research.**

19. The APA Report addressed only sexual orientation: “Due to our charge, we limited our review to sexual orientation and **did not address gender identity . . .**” (APA Rep. 9 (emphasis added).) Another Source cited by the ordinance, however, points to the same lack of empirical research on the outcomes of gender identity change efforts:

Different clinical approaches have been advocated for childhood gender discordance. **Proposed goals of treatment include reducing the desire to be the other sex**, decreasing social ostracism, and reducing psychiatric comorbidity. **There have been no randomized controlled trials of any treatment. . . .**

(Dkt. 24-1 PageID 345, 345 n.6; AACAP Statement PageID 521 (emphasis added) (footnote omitted).) Also:

**Given the lack of empirical evidence** from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, **further research is needed** on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention . . . .

(AACAP Statement PageID 522 (emphasis added).)

20. As with the APA Report, the AACAP Statement leaves discretion with licensed professionals to make an informed decision, with the patient, about the most appropriate treatment. (AACAP Statement PageID 522 (“As an ethical guide to treatment, ‘the clinician has an obligation to inform parents about the state of the empiric database’ . . . .” (footnote omitted), PageID 524 (“The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and that patient’s family, the diagnostic and treatment options available, and other available resources.”).)

21. The APA itself more recently addressed issues of gender identity and minors which were not included in the APA Report in its APA TGNC Guidelines. As a discussion separate from SOCE, these later Guidelines make the point that “[t]he constructs of gender identity and sexual orientation are theoretically and clinically distinct, even though professionals and nonprofessionals frequently conflate them.” (APA TGNC Guidelines PageID 2752.) Nonetheless, the APA recognized the same absence of research on gender identity change in children: “Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because **no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist** regarding best practice with prepubertal children.”<sup>5</sup> (*Id.* at PageID 2759 (emphasis added).) One distinct approach recognized by the APA “to address gender identity concerns in children” is an approach where “children are encouraged to embrace their given bodies and to align with their assigned gender roles.” (*Id.*) And again, calling for more research, the APA concludes, “**It is hoped that future research** will offer improved guidance in this area of practice.” (*Id.* (emphasis added) (citation omitted).)

22. Notwithstanding the APA’s call for future research, however, the APA expressly sanctioned as **imperative** allowing a minor who has selected a gender identity different from his or her biological sex to choose to return:

Emphasizing to parents the importance of allowing their child the freedom **to return to a gender identity that aligns with sex assigned at birth** or another gender identity at any point **cannot be overstated**, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth.

---

<sup>5</sup> The City’s expert Dr. Spack agrees with all premises and conclusions in this statement. (Spack 116:25–120:25, Ex. 33 (Dkt. 192-8).) The City’s other expert, Dr. Glassgold, would modify the conclusion, but only slightly, to read, “consensus does not exist, but a trend towards consensus does exist.” (Glassgold 158:13–159:24, Ex. 33 (Dkt. 192-8).)

(APA TGNC Guidelines PageID 2760 (emphasis added).) The City’s expert Dr. Spack agrees with this imperative. (Spack 123:1–17, Ex. 33 (Dkt. 192-8).)

23. Other literature by a research scientist favorably cited in the AACAP Statement positively advances treatment to assist children in fading “cross-gender identity” by the time they reach adolescence. (Heino F. L. Meyer-Bahlburg, *Gender Identity Disorder in Young Boys: A Parent- and Peer-Based Treatment Protocol*, 7 *Clinical Psychol. and Psychiatry* 360 (2002) (Dkt. 135-2 (hereinafter, “Meyer-Bahlburg”), at 361<sup>6</sup> (“We expect that we can diminish these problems if we are able to speed up the fading of the cross-gender identity which will typically happen in any case.”) (cited by AACAP Statement PageID 522 (n.100)); *see also* Meyer-Bahlburg 365 (“The specific goals we have for the boy are to develop a positive relationship with the father (or a father figure), positive relationships with other boys, gender-typical skills and habits, to fit into the male peer group or at least into a part of it, and to feel good about being a boy.”).)<sup>7</sup>

**4. The APA Report Commends a Client-Directed Approach to Therapy for Clients with Unwanted Same-Sex Attractions, Commends More Research on Voluntary SOCE, and Condemns Only Coercive Therapies.**

24. In connection with its SOCE review and recommendations, the APA Report highlighted a problem with the sexual orientation terminology in the academic research:

Recent studies of participants who have sought SOCE **do not adequately distinguish between sexual orientation and sexual orientation identity.** We concluded that the failure to distinguish these aspects of human

---

<sup>6</sup> The CM/ECF system did not affix the Court’s official filing header information, including page numbering, to the Meyer-Bahlburg study at Dkt. 135-2. Thus, citations are to the study’s original page numbering.

<sup>7</sup> Dr. Spack identified Dr. Meyer-Bahlburg as someone Dr. Spack “would trust with [standards of care for the health of transsexual, transgender, and gender-nonconforming people] - - with comments about children or adolescence.” (Spack 75:25–76:22, 77:14–79:16, 82:14–83:12, Ex. 37 (Dkt. 192-12).)

sexuality has led SOCE research to obscure what actually can or cannot change in human sexuality. . . . **[S]ome individuals modified their sexual orientation identity** (e.g., individual or group membership and affiliation, self-labeling) **and other aspects of sexuality** (e.g., values and behavior). . . . **[I]ndividuals, through participating in SOCE, became skilled in ignoring or tolerating their same-sex attractions. Some individuals reported that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity.**

(APA Rep. 3–4 (emphasis added).)

25. For adults desiring “**to change their sexual orientation** or their behavioral expression of their sexual orientation, or both,” the APA reported that “adults perceive a benefit when they are provided with **client-centered** . . . approaches” involving “identity exploration and development,” “**respect for the client’s values, beliefs, and needs,**” and “permission and opportunity to explore a wide range of options . . . **without prioritizing a particular outcome.**”

(APA Rep. 4.) The Task Force elaborated:

Given that there is diversity in how individuals define and express their sexual orientation identity, an affirmative approach is supportive of clients’ identity development **without an a priori treatment goal concerning how clients identify or live out their sexual orientation or spiritual beliefs.** This type of therapy . . . can be helpful to those who accept, reject, or are ambivalent about their same-sex attractions. **The treatment does not differ, although the outcome of the client’s pathway to a sexual orientation identity does.**

(APA Rep. 5 (emphasis added).) “For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration **for those distressed by their sexual orientation** may be: LGB identities[,], **Heterosexual sexual orientation identity**[,], Disidentifying from LGB identities[, or] Not specifying an identity.” (APA Rep. 60 (emphasis added) (citations omitted).)

26. The affirmative approach endorsed by the APA Report, with no a priori treatment goal on the part of the therapist, can be applied to both “a client who experiences same-sex

attraction and wants to . . . align attractions with a heterosexual identity and also to a client who experiences same-sex attraction and does not want to align with a heterosexual identity . . . .”

(Glassgold 130:21.)

27. A key finding from the Task Force’s review “is that those who participate in SOCE, **regardless of the intentions of these treatments**, and those who resolve their distress through other means, **may evolve during the course of their treatment in such areas as self awareness, self-concept, and identity.**” (APA Rep. 66 (emphasis added); *id.* at 61 (“Given . . . that many scholars have found that **both religious identity and sexual orientation identity evolve**, it is important for LMHP to explore the development of religious identity and sexual orientation identity.” (emphasis added) (citations omitted)).)

28. The Task Force identifies the **same essential framework** “for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to change.”<sup>8</sup> (APA Rep. 5.) Specifically, for children and youth, “[s]ervices . . . should support and respect age-appropriate issues of **self-determination**; services should also be provided in the least restrictive setting that is clinically possible and should maximize self-determination. At a minimum, **the assent of the youth should be obtained, including whenever possible a developmentally appropriate informed consent to treatment.**” (*Id.* (emphasis added).)

29. The Task Force also highlighted the ethical importance of client self-determination, encompassing “the ability to seek treatment, consent to treatment, and refuse treatment. **The informed consent process is one of the ways by which self-determination is maximized in**

---

<sup>8</sup> The APA Report defines “*adolescents* as individuals between the ages of 12 and 18 and children as individuals under age 12.” (APA Rep. 71 n.58.)

**psychotherapy.**” (APA Rep. 68 (emphasis added); *see also id.* at 6 (“LMHP **maximize self-determination** by . . . providing effective psychotherapy that explores the client’s assumptions and goals, without preconditions on the outcome [and] **permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation.** . . . [T]herapy that increases the client’s ability to cope, understand, acknowledge, and integrate sexual orientation concerns into **a self-chosen life** is the measured approach.”).)

30. The Task Force viewed the concept of self-determination as equally important for minors: “It is now recognized that **adolescents are cognitively able to participate in some health care treatment decisions**, and such participation is helpful. [The APA] encourage[s] professionals to seek the assent of minor clients for treatment.” (APA Rep. 74 (emphasis added) (citations omitted); *see also id.* at 77 (“The ethical issues outlined [for adults] are also relevant to children and adolescents . . .”).)

31. In light of this strong self-determination ethic regarding youth, the Task Force “recommend[ed] that when it comes to treatment that purports to have an impact on sexual orientation, **LMHP assess the adolescent’s ability to understand treatment options, provide developmentally appropriate informed consent to treatment, and, at a minimum, obtain the youth’s assent to treatment.**” (*Id.* at 79 (emphasis added).) “[F]or children and adolescents who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change,” the Task Force recommended “**approaches [that] support children and youth in identity exploration and development without seeking predetermined outcomes.**” (*Id.* at 79–80 (emphasis added).) “LMHP should strive to maximize autonomous decision making and self-determination and **avoid**

**coercive and involuntary treatments.”**<sup>9</sup> (*Id.* at 76 (emphasis added).) “The use of **inpatient and residential treatments** for SOCE is inconsistent with the recommendations of the field.” (*Id.* at 74–75 (emphasis added).)

32. Apart from recommending against coercive, involuntary, and residential treatments, the Task Force **did not recommend the end of SOCE**. Rather, without empirical evidence of efficacy or harm, the Task Force merely recommended that clients not be lead to **expect** a change in sexual orientation through SOCE. (APA Rep. 66.) The Task Force cited literature expressly **cautioning against declining SOCE** therapy for a client who requests it.

LMHP who turn down a client’s request for SOCE at the onset of treatment without exploring and understanding the many reasons why the client may wish to change may instill hopelessness in the client, who already may feel at a loss about viable options. . . . **[B]efore coming to a conclusion regarding treatment goals, LMHP should seek to validate the client’s wish to reduce suffering and normalize the conflicts at the root of distress**, as well as create a therapeutic alliance that recognizes the issues important to the client.

(APA Rep. 56 (emphasis added) (citation omitted).)

33. The Task Force also called for more research on SOCE. (APA Rep. 90 (“Any future research should conform to best-practice standards for the design of efficacy research. Additionally, **research into harm and safety is essential.**”), 91 (“**Future research** will have to better account for the motivations and beliefs of participants in SOCE.”), 91 (“**This line of research should be continued and expanded to include conservatively religious youth and their families.**”) (all emphases added).) The Task Force’s call for future research implicitly

---

<sup>9</sup> The APA Report defines “*coercive treatments* as practices that compel or manipulate a child or adolescent to submit to treatment through the use of threats, intimidation, trickery, or some other form of pressure or force.” (APA Rep. 71 n.59.) It defines “*involuntary treatment* as that which is performed without the individual’s consent or assent and which may be contrary to his or her expressed wishes.” (*Id.* at 71 n.60.)

rejected the suggestion by some that “SOCE should not be investigated or practiced until safety issues have been resolved.” (*Id.* at 91.)

34. Given the absence of empirical evidence on SOCE outcomes, and the emphasis on client-centered approaches, the Task Force recommended that choosing SOCE counseling be given to the discretion of licensed mental health providers (LMHP):

[The APA Ethics Code] establishes that psychologists aspire to provide services that maximize benefit and minimize harm. . . . When applying this principle in the context of providing interventions, **LMHP assess the risk of harm, weigh that risk with the potential benefits, and communicate this to clients through informed consent procedures** that aspire to provide the client with an understanding of potential risks and benefits that are accurate and unbiased. . . .

In weighing the harm and benefit of SOCE, LMHP can review with clients the evidence presented in this report. Research on harm from SOCE is limited, and some of the research that exists suffers from methodological limitations that make broad and definitive conclusions difficult. . . .

(APA Rep. 67 (emphasis added) (citations omitted); *see also id.* at 6 (“LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, such as the evidence provided in this report.”).)

**5. The APA Report Specifically Calls for Therapists to Respect and Consider the Religious Values of Individuals Desiring Therapy.**

35. The Task Force highlighted the particular stress experienced by individuals of conservative religious faiths who “struggle to live life congruently with their religious beliefs,” and that this stress “had mental health consequences.” (APA Rep. 46–47.) “Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion . . . .” (*Id.* at 47.) It “**proposed an approach that respects religious values and welcomes all of the client’s actual and potential identities** by

exploring conflicts and identities without preconceived outcomes. This approach does not prioritize one identity over another and **may aide a client in creating a sexual orientation identity consistent with religious values.**” (APA Rep. 67 (emphasis added) (citation omitted).) “Although there are tensions between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive.” (APA Rep. 67 (citations omitted).)

**6. No Study Since the 2009 APA Report Updates or Changes the Empirical Record.**

36. None of the studies subsequent to the 2009 APA Report cited by Dr. Glassgold in her declaration or identified at her deposition updated the empirical record or contradicted the conclusions from APA Report on the lack of causal attribution of harm to SOCE (*see supra* ¶¶ 11–14), or the AACAP Statement and APA TGNC Guidelines on the absence of research and consensus on addressing gender identity concerns in minors (*see supra* ¶¶ 19–21), including the 2015 SAMHSA report attached to Dr. Glassgold’s declaration as Exhibit C (with which she was personally involved) (PageID 568 (“**No new studies have been published that would change the conclusions reached in the APA Taskforce’s 2009 review.**” (emphasis added)), PageID 569 (“**[N]o research demonstrating the harms of conversion therapy with gender minority youth has been published . . . .**” (emphasis added))), up to and including the most recent study Dr. Glassgold cited, published in 2018 by Ryan, et al. (Dkt. 142-3 Page ID 3234 (“**[C]ausal claims cannot be made.**” (emphasis added)). (Glassgold 134:18–155:5, 175:15–180:18; Ex. 28 (Dkt. 192-3) ¶ 17 at 7–8, 8 n.7, Ex. C; Exs. 29–32 (Dkts. 192-4 to 192-7).)

37. The 2009 endocrine treatment guidelines Dr. Spack co-authored, which are attached as Exhibit B to his Declaration, apply to treatments that occur after a mental health professional first determines a minor presents with gender dysphoria or a condition indicating endocrine treatments. (Spack 46:2–46:23; 58:11–59:14, 69:23–71:14, Ex. 36 (Dkt. 192-11).) In

Dr. Spack's opinion, the assessment of "whether the kid is the real deal" must be performed by a mental health professional experienced in dealing with gender identity disorders. (Spack 69:23–70:14.)

38. The endocrine guidelines recommend against social transition for prepubertal children who exhibit "cross-gender behavior, but not so much as to qualify as being transgender," because many of them will not persist with gender dysphoria or gender identity disorder after the onset of puberty. (Spack 71:19–74:16.) Dr. Spack believes it is important that "incredibly skillful psychologists" determine whether children fit into this category, and that a non-psychologist without education beyond high school would not be able to make the determination. (Spack 74:17–75:19.)

39. The WPATH standards identified by Dr. Spack in his declaration endorse the view that "[o]ften with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body." (Spack 75:25–76:22, 77:14–78:16, 83:15–84:6, Exs. 36, 37 (Dkts. 192-11, 192-12).) Dr. Spack testified that this view applies to some prepubertal children. (Spack 85:19–86:11.) The WPATH standards also report that gender dysphoria persisted into adulthood for only 6–23% of prepubertal boys, and 12–27% of prepubertal girls, but that "[n]o formal prospective studies exist" for adolescents. (Spack 86–88:21, Ex. 37 (Dkt. 192-12).) Also, "formal epidemiologic studies on gender dysphoria in children, adolescents, and adults are lacking." (Spack 91:24–92:10, Ex. 37 (Dkt. 192-12).)

40. A 2015 article cited in Dr. Spack's declaration, that he co-authored, teaches there are complex issues of disagreement between "providers in the field" who "work in the best interest of the youth they serve," including:

differing assumptions regarding whether early intervention with gender variant youth can encourage desistance, and whether that is an appropriate practice[;] . . . the age at which children (or adolescents) should be encouraged or permitted to socially transition; whether cross-sex hormones and surgery should be offered to youth, and if so, at what age; whether parental consent be required for these medical interventions; and whether mental health involvement be required, including psychological evaluation, prior to each stage of medical intervention.

(Spack 97:23–98:19, 109:20–111:12, Ex. 40 (Dkt. 192-15) at 11.) Dr. Spack agrees that “these complex issues of disagreement continue” in 2019. (*Id.*)

**F. Tampa Did Not Tailor the Ordinance to Any Identified Interest or the Realities of SOCE Counseling.**

41. The City Council Member who introduced the ordinance, Guido Maniscalco, desired to ban “torture” and other coercive therapy forced on unwilling minors, such as electroshock treatments and verbal and mental abuse. (Maniscalco 26:21–32:6; Pls.’ Dep. Ex. 6, Dkt. 134-6; PI Hr’g 38:22–44:25.) But the City did not consider any alternatives to the ordinance’s total ban. (MPI R&R 28; *see also* Maniscalco 100:14–102:9 (“**We never debated anything else** because we specifically wanted the complete ban.” (emphasis added)); 140-1 Slides 43–45; PI Hr’g 78:1–82:11.)

**G. Tampa Code Officials Are Not Qualified or Equipped to Enforce the Ordinance’s Therapy Ban.**

42. The City’s code enforcement officials tasked with enforcing the ordinance need only a high school diploma or equivalent for the position, and receive no training in marriage and family therapy or mental health counseling. (Ruggiero 19:24–20:25; 140-2 Slides 2; PI Hr’g 85:15–88:14.) The officials are not trained to distinguish “conversion therapy” from other therapy, or qualified to tell the difference between “sexual orientation” and “gender identity,” or how to know, for example, whether a child experiencing gender confusion has transitioned to a cross-gender identity or is still exploring the possibility. (Ruggiero 69:16–70:7, 79:17–80:8, 100:12–

101:25; 140-2 Slides 3, 5–7; PI Hr’g 88:15–89:11, 89:23–92:21.) Nonetheless, code officials must know what the ordinance prohibits in order to enforce it, and to fulfill their responsibilities to issue notices of violation. (Ruggiero Dep., Dkt. 133-1 at 25:8–11, 77:7–10; 140-2 Slides 4, 8; PI Hr’g 89:12–22, 92:22–93:7.)

43. Tampa code officials do not enforce any other ordinances regulating the therapies offered by mental health professionals, and have no experience or expertise in enforcing such regulations. (Ruggiero 71:15–72:9; Simpson 111:13–25; 140-2 Slides 21–22; PI Hr’g 98:11–113:14.)

44. Tampa code officials are instructed to refer all potential “conversion therapy” cases to the City’s legal department for handling. (Ruggiero 24:10–25; Pls.’ Dep. Ex. 2, Dkt. 134-2, at 15; 140-2 Slides 9–11; PI Hr’g 93:8–95:14.) The City’s lawyer responsible for overseeing “conversion therapy” enforcement, however, cannot define the term “gender identity” as used in the ordinance, and would look to the dictionary to interpret the ordinance. (Simpson 67:20–68:17; 140-2 Slides 12; PI Hr’g 95:15–97:12.) The ultimate trier of ordinance violations is a City-appointed special master, but the City does not know whether any special master on its roster is a licensed mental health practitioner, and the City has no plans to appoint a special master with those credentials. (Simpson 104:9–16; 140-2 Slides 13; PI Hr’g 97:13–98:10.)

Respectfully submitted,

/s/ Roger K. Gannam  
Mathew D. Staver  
Horatio G. Mihet  
Roger K. Gannam  
Daniel J. Schmid  
LIBERTY COUNSEL  
P.O. Box 540774  
Orlando, FL 32854  
Phone: (407) 875-1776  
Fax: (407) 875-0770  
E-mail: rgannam@LC.org  
*Attorneys for Plaintiffs*

**CERTIFICATE OF SERVICE**

I hereby certify that on this August 26, 2019, I caused a true and correct copy of the foregoing to be filed electronically with the Court's CM/ECF system. Service upon all counsel of record will be effectuated by the Court's electronic notification system.

/s/ Roger K. Gannam  
Roger K. Gannam  
*Attorney for Plaintiffs*