UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Robert L. Vazzo, LMFT, et al.,

Plaintiffs,

v.

City of Tampa, Florida,

Defendant.
_____/

Case No. 8:17-cv-02896-WFJ-AAS

DISPOSITIVE MOTION

DEFENDANT THE CITY OF TAMPA'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND MOTION TO EXCLUDE EXPERT OPINIONS

Defendant, the City of Tampa, under Federal Rule of Civil Procedure 56 responds in opposition to Plaintiffs' Motion for Summary Judgment and Motion to Exclude Certain Opinions of Defendant's Expert and Incorporated Memorandum of Law, and states as follows:

INTRODUCTION

This case is about the protection of minor children. As stated in the City's previous submissions, the City has a compelling governmental interest in safeguarding this vulnerable class from the serious harms associated with conversion therapy, which has been rejected by our nation's leading medical and mental health organizations because it puts minors at risk of suicide and other serious harms.[1] Based on that professional consensus, the City enacted Tampa Ordinance 2017-47, which prohibits licensed counselors from practicing conversion therapy on minors.

[1] The City hereby incorporates by reference the arguments raised in its Motion for Summary Judgment and Incorporated Memorandum of Law. (Doc. 189.)

ARGUMENT

I. PLAINTIFFS ARE NOT ENTITLED TO SUMMARY JUDGMENT AS A MATTER OF LAW ON THEIR CONSTITUTIONAL CLAIMS

The Ordinance governs mental health treatment, not speech. For this reason, it is entitled to no special First Amendment protection. But even if the Ordinance were analyzed as a regulation of speech, regulations requiring licensed professionals to adhere to professional standards while providing services to clients are subject at most to intermediate scrutiny, which the Ordinance easily passes. Even under strict scrutiny, the Ordinance is constitutional because it is narrowly tailored to further the City's compelling interest of protecting children from serious physical and psychological harm. Because the Ordinance survives any level of constitutional scrutiny, the Plaintiffs' Motion for Summary Judgment should be denied.

A. The Ordinance is a Regulation of Treatment, not Speech.

The Supreme Court has made clear that the government may regulate specific medical treatments as long as it has a rational basis for doing so, even if such regulation incidentally affects a professional's speech. *National Inst. of Fam. & Life Advocates v. Becerra,* __ U.S. __, 138 S. Ct. 2361 (2018) *("NIFLA")*). Plaintiffs say that precedent precludes this Court from finding that the Ordinance governs conduct, but each case Plaintiffs rely upon is readily distinguishable.

Plaintiffs' attempt to cast the Ordinance as an improper regulation of speech cannot be squared with the longstanding recognition that governments may regulate medical practices that are harmful to public health and safety. *Gonzales v. Carhart,* 550 U.S. 124, 157 (2007) ("Under our precedents it is clear the State has a significant role to play in regulating the medical profession."). The Supreme Court has long recognized that governments have the

authority to "regulate professional conduct, even though that conduct incidentally involves speech." *NIFLA*, 138 S. Ct. 2361 (2018) (citing *Ohralik v. Ohio State Bar Ass'n.*, 436 U. S. 447, 456 (1978)). In particular, as the Supreme Court held in *Planned Parenthood of Southeast Pa. v. Casey*, states may regulate speech that is "part of the practice of medicine subject to reasonable licensing and regulation." *Planned Parenthood of Southeast Pa. v. Casey*, 505 U.S. 833, 884 (1992). *NIFLA* reaffirmed *Casey*'s holding and stated that when speech is "tied to a medical procedure" conducted by a licensed professional, it is subject to reasonable regulation by the state. *NIFLA*, 138 S. Ct. at 2373.

Here, the Ordinance regulates the practice of licensed mental health practitioners by prohibiting a specific type of treatment that the City Council, as a duly elected legislative body, reasonably determined to be harmful to minors. That prohibition applies to the administration of conversion therapy by any means, whether it be through drugs, behavioral modification, or verbal therapy. While the regulated conduct—the practice of conversion therapy on minors—may be carried out through verbal therapy, "it has never been deemed an abridgment of freedom of speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed." *Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*, 547 U.S. 47, 62 (2006)); *see also Sorrell v. IMS Health Inc.*, 564 U.S. 552, 567 (2011) ("[T]he First Amendment does not prevent restrictions directed at . . . conduct from imposing incidental burdens on speech"). Because the Ordinance regulates treatment only and leaves mental health providers free to discuss, recommend, and advocate for conversion therapy, the Ordinance is subject to, and easily survives, rational basis review. *Pickup v. Brown*, 740 F.3d 1208, 1231

(9th Cir. 2014) (applying rational basis review in upholding constitutionality of conversion therapy ban) (citing *Casey*, 505 U.S. at 884, 967–68, 112 S.Ct. 2791).

Plaintiffs contend that *NIFLA*, *Wollschlaeger v. Governor of Florida*, 848 F.3d 1293 (11th Cir. 2017) (en banc), and *Holder v. Humanitarian Law Project*, 561 U.S. 1, 26 (2010) mandate that the Court analyze the Ordinance under strict scrutiny. But none of these cases supports Plaintiffs' argument. *NIFLA* and *Wollschlaeger* addressed laws that regulated speech as such—not speech tied to the provision of a medical procedure. *See NIFLA*, 138 S. Ct. at 2373 (noting that the regulated speech was not "tied to a [medical] procedure at all"; *Wollschlaegger*, 848 F.3d at 1317 (finding that the law regulated speech as such and required doctors to violate, not follow, professional standards of care). In contrast, to the extent speech is even implicated here, it is only as "*the manner of delivering the treatment.* Plaintiffs are essentially writing a prescription for a treatment that will be carried out verbally." *Otto*, 353 F. Supp. 3d at 1256.

The facts in *Holder* are even more remote from those here. As the Ninth Circuit noted in *Pickup*, the law in *Holder* applied to "political speech" by "ordinary citizens," not to the regulation of a harmful treatment by licensed mental health professionals. The statute in *Holder* made it a federal crime for ordinary citizens to "knowingly provide material support or resources to a foreign terrorist organization." 561 U.S. 1, 26 (2010). The plaintiffs sought to communicate information about international law to a designated terrorist organization but were barred from doing so by the statute. The government argued that because the statute generally barred conduct (aiding terrorist groups), the Court should analyze the plaintiffs' prohibited speech as mere conduct as well. The Supreme Court upheld the statute, but found

that as applied to plaintiffs it restricted protected political speech. The Court held that even though the material support statute "may be described [generally] as directed at conduct," strict scrutiny applied because "the [specific] conduct triggering coverage under the statute consists of communicating a message." *Holder*, 561 U.S. at 28. Plaintiffs erroneously seize upon this language to argue that the Ordinance also regulates speech as such and must be subject to strict scrutiny. Nothing in *Holder* altered *Casey*'s holding that laws regulating medical treatments provided by licensed professionals are permissible even if they incidentally impact speech—a holding later reaffirmed in *NIFLA*.

Unlike the law at issue in *Holder,* the Ordinance applies only to licensed mental health professionals, not ordinary citizens, and does not prohibit Plaintiffs from communicating a message. The conduct triggering the Ordinance does not consist of communicating a message, but rather is the provision of a specific mental health treatment to an individual. Plaintiffs are free to express their views on conversion therapy to anyone, including minor patients and their parents, including their views on conversion therapy. The only thing prohibited is actually providing conversion therapy. As the Ninth Circuit in *Pickup v. Brown* correctly found, *Holder* does not support Plaintiffs' position. *Pickup v. Brown*, 740 F.3d 1208, 1229 (9th Cir. 2014).

Plaintiffs also take issue with *Otto v. City of Boca Raton*, 353 F. Supp. 3d 1237, 1257 (S.D. Fla. 2019), mischaracterizing the court's holding as applying an "alternative labeling of speech as 'treatment.'" In *Otto*, the district court carefully considered a First Amendment challenge to ordinances almost identical to the Ordinance at issue in this case and denied a preliminary injunction on the basis that plaintiffs failed to establish a likelihood of success on the merits of their First Amendment challenge. As the *Otto* court accurately noted, "[p]laintiffs'

words serve a function; their words constitute an act of therapy with their minor clients, which makes [the] plaintiffs' speech different from the protected dialogues in *Wollschlaeger* and *NIFLA*, and from highly protected, political speech in the metaphoric or literal '"public square."' *Id.* at 1257. For this reason, the *Otto* correctly declined to apply strict scrutiny. *Id.* at 1256. This Court should do the same.

B. Even If Analyzed as a Regulation of Speech, Only Intermediate Scrutiny Applies.

Even if this Court were to analyze the Ordinance as a regulation of professional speech, the highest level of scrutiny that should be applied is intermediate scrutiny. Plaintiffs argue that strict scrutiny applies, relying on the Supreme Court's decision in *Reed v. Town of Gilbert*, __U.S. __, 135 S. Ct. 2218 (2015) (holding that content-based restrictions on speech are generally subject to strict scrutiny). But as the Eleventh Circuit has cautioned, *Reed* did not address regulations of speech that have long been recognized as being subject to a lesser form of scrutiny. *Flanigan's Enterprises, Inc. of Georgia v. City of Sandy Springs*, 703 F. App'x 929, 933 (11th Cir. 2017). And *NIFLA*, while recognizing the general rule concerning content-based regulations, expressly affirmed after *Reed* that the conduct of medical professionals may be regulated even if such regulation incidentally impacts speech.

Thus, Plaintiffs' expansive reading of *Reed* cannot be applied here to regulations that enforce professional standards of safety and ethics. As the court in *Otto* recognized, "applying intermediate scrutiny [at most] to medical treatments that are effectuated through speech would strike the appropriate balance between recognizing that doctors maintain some freedom of speech within their offices, and acknowledging that *treatments* may be subject to significant regulation under the government's police powers." 353 F. Supp. 3d at 1256. Since the

Ordinance is a regulation of only licensed mental health providers and does not compel or limit speech other than that which is part of a specific medical treatment, it warrants intermediate scrutiny at most, which the Ordinance readily survives.

C. The City has a Compelling Interest to Protect the Psychological and Physical Wellbeing of Minors.

Plaintiffs raise two main arguments against the City's compelling interest in protecting the wellbeing of minors.[2] First, they argue that the City's legislative determination that conversion therapy poses an unacceptable risk of harm to minors is not entitled to substantial deference. Second, they argue that the 2009 American Psychological Association ("APA") Report does not establish empirical evidence of harm. Both arguments fail.

Substantial Deference. The Supreme Court has repeatedly recognized that governments have "a compelling interest in protecting the physical and psychological well-being of minors." *Sable Commc'ns of California, Inc. v. FCC*, 494 U.S. 115, 126 (1989). Every major medical, psychiatric, psychological, and professional mental health organization has rejected the practice of conversion therapy on minors because it puts minors at risk of suicide and other serous harms, while providing no unique benefits. The City's reliance on that overwhelming professional consensus in enacting the Ordinance is entitled to substantial deference, as the Supreme Court has made clear. *See Turner Broad. Sys., Inc. v. F.C.C.*, 512 U.S. 622, 665–66 (1994) (holding that courts must give substantial deference to the predictive judgments of legislative bodies).

[2] Plaintiffs' challenge to the expert opinion of Dr. Judith Glassgold will be addressed separately below.

Plaintiffs' argument that the City did not rely on empirical evidence of harm has no merit. "Legislatures are entitled to rely on the empirical judgments of independent professional organizations that possess specialized knowledge and experience concerning the professional practice under review, particularly when this community has spoken with such urgency and solidarity on the subject." *King v. Governor of the State of New Jersey*, 767 F.3d 216, 238 (3d Cir. 2014); *Otto*, 353 F.Supp. 3d at 1262 ("To the extent Plaintiffs quarrel with the empirical nature of the cited position papers and studies, courts "have permitted litigants to justify speech restrictions by reference to studies and anecdotes pertaining to different locales altogether, or even, in a case applying strict scrutiny, to justify restrictions based solely on history, consensus, and 'simple common sense.' ") (quoting *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 555, 121 S.Ct. 2404, 150 L.Ed.2d 532 (2001) (quotations omitted)). That is precisely what the City did here. The Ordinance is supported by substantial research, professional association reports and policies, and expert clinical guidance, much of which is set forth in the findings accompanying the Ordinance.

Plaintiffs erroneously analogize that comprehensive professional consensus to the "six anecdotes" in which doctors and medical professionals purportedly asked unwelcome questions or made purportedly improper comments regarding their ownership of firearms, which were the sole evidence relied upon by the state to justify the gun law at issue in *Wollschlaeger*. *Wollschlaeger*, 848 F.3d at 1302. As the Eleventh Circuit noted, "[t]here was no other evidence, empirical or otherwise, presented to or cited by the Florida Legislature." In considering whether the six anecdotes were sufficient to demonstrate harms that are "real, [and] not merely conjectural," such that the FOPA provisions "will in fact alleviate these harms

in a direct and material way," the court found that they did not. *Id.* at 1312 (citing *Turner Broad. Sys., Inc. v. F.C.C.*, 512 U.S. 622, 664, 114 S.Ct. 2445 (1994)).

In stark contrast to that woefully deficient legislative record, the City here relied upon numerous studies, including the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's 2015 report ("SAMHSA Report") and the American Psychological Association ("APA") 2009 report, as well as the consensus of numerous national medical and mental health professional organizations, all of which concluded that conversion therapy places minors at an unacceptably high risk of serious harm, including death by suicide. This professional consensus, compiled over decades and supported by peer-reviewed research, is a far cry from the handful of anecdotes that formed the sole evidentiary basis for the statute struck down in *Wollschlaeger*.

Because the City relied upon substantial evidence in concluding that conversion therapy offers no unique mental health benefit and places Tampa's minors at risk of harm, this Court should afford substantial deference to the legislative facts embodied in the Ordinance and the City's compelling interest in protecting minors from this harm.

Empirical Evidence of Harm. Plaintiffs further argue that there is "no empirical evidence of harm from conversion therapy." The record demonstrates otherwise. The APA 2009 Report found that conversion therapy for minors is ineffective: "We found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation." (Doc. 24-2, p. 46.) In addition, the Report found that the available data demonstrated evidence of harm from conversion therapy: "[S]cientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its

participants." (Doc. 24-3, p. 2.) The APA Report cited recent studies documenting harm. With respect to recent studies, "the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction." (Doc. 24-2, p. 9.) The APA Report concluded that licensed mental health providers should not engage in sexual orientation change efforts with minors under any circumstances, regardless of whether techniques are aversive or non-aversive, and including for "children and adolescents who present a desire to change their sexual orientation": "We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families rather than SOCE. . . . These approaches would support children and youth in identity exploration and development without seeking predetermined outcomes." (Doc. 24-2, pgs. 46-47) (emphasis added).

In 2015, the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services conducted an updated survey of existing research on conversion therapy and published a report and recommendations based on "consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance." (Doc. 24-4, p. 42) ("SAMHSA Report"). The report found "none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation." *Id.* It concluded that "[i]nterventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity,

gender expression, and sexual orientation are coercive, can be harmful, and should not be a part of behavioral health treatments." Plaintiffs point to a statement in the SAMHSA report that "[n]o new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review," but that only confirms the continued absence of any methodologically-sound research showing that conversion therapy on minors is either safe or effective.

Similarly, Plaintiffs ignore the peer-reviewed 2018 Ryan study, which found that youth who were subjected to conversion therapy were nearly *three times more likely to attempt suicide* than other LGBT youth. These youth also experienced negative long-term effects such as serious depression, lowered life satisfaction, less social support, lower socioeconomic status, and other serious difficulties in their young adulthood that could impact them over the long term. (Doc. 192-1.)

The City Council was entitled to rely on the "empirical judgments of independent professional organizations that possess specialized knowledge and experience concerning the professional practice under review. . ." *King v. Governor of the State of New Jersey*, 767 F.3d 216, 238 (3d Cir. 2014). In light of the overwhelming consensus of the mental health scientific community that conversion therapy provides no unique benefits and puts minors at risk of life-threatening harm, the City has a constitutionally sufficient interest in protecting minor children from these harms under any standard of review.

C. The Ordinance is Narrowly Tailored to Achieve the City's Compelling Interest in Protecting Minors from Life Threatening Harm.

Prohibiting licensed therapists in Tampa from practicing conversion therapy on minors is the least restrictive means to serve the City's compelling interest in protecting minors from the serious harms associated with that treatment. The Ordinance applies only to minors receiving conversion therapy from licensed providers within the City limits. The Ordinance does not apply to religious leaders or unlicensed counselors. In addition, the Ordinance applies only to the actual provision of conversion therapy to minors. It does not limit a provider's expression of views on conversion therapy. Nor does it prevent providers from recommending or discussing conversion therapy with patients or others, from publishing or writing about conversion therapy, or from otherwise communicating their views in any setting. The sole impact is to prevent licensed therapists from actually engaging in conversion therapy with minor patients.

Despite that extremely narrow and targeted focus, Plaintiffs argue that (1) the City failed to show that less restrictive alternative means would be unworkable; and (2) the Ordinance is not narrowly tailored because it is "practically unenforceable by City Code Officials." Both these arguments fail.

First, Plaintiffs' argument that the City must actually have *tried* alternative measures and failed in order to satisfy the narrow tailoring requirement is not supported by *McCullen v. Coakley*, 573 U.S. 464 (2014) or any other binding precedent. In *McCullen*, the Supreme Court considered the constitutionality of a thirty-five foot buffer zone around entrances to abortion providers in Massachusetts. The Supreme Court struck down the law after finding that it was not narrowly tailored because the buffer zone burdened substantially more speech than

necessary to achieve the state's interests. *Id.* at 496. In so finding, the Supreme Court determined that the Commonwealth's content-neutral interest in preventing congestion in front of abortion clinics could be achieved through more targeted means by enacting laws that other localities had enacted and that had proven effective. *Id.* at 494.

Unlike *McCullen* where the Commonwealth had not considered methods other jurisdictions found to be effective, the City here did consider the experience of other jurisdictions. States and localities across the country have adopted nearly identical ordinances or laws to prohibit conversion therapy which prohibit medical providers from performing conversion therapy on minors. *See Otto*, 353 F. Supp. at n.15 (noting statewide bans on conversion therapy performed on minors and local bans on conversion therapy performed on minors). In fact, the City specifically found that "minors receiving treatment from licensed therapists in the City of Tampa, Florida who may be subject to conversion or reparative therapy are not effectively protected by other means. . . ." (Doc. 24-1, p. 5.) Plaintiffs have identified no other jurisdiction which has adopted other methods that can effectively achieve the City's goals. None exist. The City, like numerous other jurisdictions, has enacted a ban on conversion therapy for minors because it is the only effective means to meet the City's compelling interest in protecting children from harm.

McCullen required only that the government "demonstrate that alternative measures that burden substantially less speech would fail to achieve the government's interests," not that the government actually tried alternatives and failed. *McCullen*, 573 U.S. at 495. Plaintiffs attempt to impose a higher burden on the City by relying on the Third Circuit's decision in *Bruni v. City of Pittsburgh*, arguing that the City must "show either that substantially less-

restrictive alternatives were tried and failed, or that the alternatives were closely examined and ruled out for good reason." 824 F.3d 353, 370 (3d Cir. 2016). Even the concurring opinion in that non-binding case disagreed with that approach. The concurrence stated "[t]hat interpretation distorts narrow-tailoring doctrine" and "[n]othing in *McCullen* or the Supreme Court's First Amendment jurisprudence requires us to apply such a rule." *Id.* at 375. In short, the City has satisfied the *McCullen* standard by demonstrating that alternative measures would fail to achieve its interest in protecting minor children from the harms of conversion therapy.

Moreover, as the City has already shown, even if a more stringent standard applied, the City would meet it here because the professional consensus relied upon by the City directly addresses—and rebuts—the suggestion that minors would be sufficiently protected from harm by permitting mental health professionals to engage only in so-called "non-aversive" or "non-coercive" forms of conversion therapy. This is because conversion therapy for minors is inherently "coercive." (Doc. 24-4.) Adolescents and children often "agree" to such practices out of fear of disapproval, loss of love, rejection, or outright abandonment by their family, community, and/or peer group. (Doc. 24-2, p. 43.) Minors' lack of legal and economic independence renders them especially vulnerable to pressure to engage in conversion therapy. *Id.* Thus, alternative means of allowing only non-aversive conversion therapy would not appropriately address the harms to minors.

Second, Plaintiffs argue that City officials are not licensed mental health professionals, and therefore, not qualified to "make determinations about appropriate mental health therapeutic practices." But nothing in the Ordinance requires City Officials to make determinations of appropriate mental health treatments. Upon receipt of a complaint for

violation of the Ordinance, the City Officials are to refer the matter to the City Attorney's Office for evaluation and, if necessary, prosecution. (Doc. 133-1, Ruggiero Dep. 24:16-25:5.) It is within the discretion of the City's legal department as to whether based upon the specific facts of each case a violation occurred under the express terms of the Ordinance, which turns solely on whether a therapist has subjected a minor to attempts to change the minor's sexual orientation or gender identity.

Plaintiffs also point to Dr. Spack's testimony that some individuals are "gender-fluid" to demonstrate the City's purported inability to enforce the Ordinance. But simply because gender fluidity exists does not mean that gender-fluid minors should be subjected to conversion therapy, or that it is not harmful. To the contrary, the purpose of the Ordinance is to prevent a therapist from imposing a predetermined outcome on their minor patients, whatever their gender identity may be. Just a week ago, the Journal of American Medical Association ("JAMA") Psychiatry published findings from a cross-sectional study of more than 27,000 transgender individuals. The study's conclusions, drawn from an extraordinarily large population sample, found that exposure to gender identity change efforts is "associated with adverse mental health outcomes in adulthood, including severe psychological distress, lifetime suicidal ideation, and lifetime suicide attempts." (Ex. A, p. 9.) The study's authors specifically reaffirmed the conclusions of the leading mental health organizations "that gender identity conversion therapy should not be conducted for transgender patients." (Ex. A, p. 8.) This peer-reviewed research provides further support for the City's decision to protect youth from the serious harms associated with therapy that attempts to change a child's gender identity.

In sum, the Ordinance requires no special expertise to be enforced according to its express terms, and it is narrowly tailored to protect the City's interest in protecting minor children from a practice that all major medical, psychiatric, psychological, and professional mental health organization seek to end.

D. The Ordinance Does Not Discriminate Based on Viewpoint.

Plaintiffs argue that the Ordinance is viewpoint discriminatory and the language of the Ordinance itself reveals its discrimination. Not so. Viewpoint discrimination occurs when the government favors "one speaker over another" or when speech is prohibited "because of its message." *Rosenberger v. Rector & Visitors of Univ. of Virginia*, 515 U.S. 819, 829 (1995). But a review of the language itself makes clear that the purpose is to proscribe the practice of conversion therapy on minors, not Plaintiffs' viewpoint about gender identity or sexual orientation. Consistent with that purpose, the Ordinance excludes from the definition of conversion therapy "counseling that provides support and assistance to a person undergoing gender transition." This is because providing such counseling and support is consistent with professional standards, is not conversion therapy, and does not cause the harms that the Ordinance is tailored to prevent. *McCullen v. Coakley*, 574 U.S. 464, 481 (2014) ("The First Amendment does not require States to regulate for problems that do not exist.") (quoting *Burson v. Freeman*, 504 U.S. 191, 207 (1992) (plurality opinion)). Plaintiffs attack the Ordinance for allowing support and assistance as being viewpoint discriminatory, but as the Eleventh Circuit held in *Keeton v. Anderson-Wiley*, 664 F.3d 865, 874 (11th Cir. 2011), "the generally applicable rules of ethical conduct of the profession are not designed to suppress

ideas or viewpoints but apply to all regardless of the particular viewpoint the counselor may possess." The same is true here.

Plaintiffs reliance on the Ninth Circuit opinion in *Conant v. Walters,* 309 F.3d 629 (9th Cir. 2002) is misplaced. In *Conant*, the court considered a federal policy that threatened doctors with revocation of their prescription authority for the "recommendation or approval" of using marijuana for medical purposes. *Id.* at 637-39. The Ninth Circuit found that the federal policy violated the First Amendment and was viewpoint discriminatory because it prohibited the mere expression of the view that medical marijuana would likely help a specific patient. *Id.* at 637. But unlike the federal policy at issue in *Conant*, the City's Ordinance does not prohibit practitioners from *recommending* conversion therapy to their patients. Licensed providers are free to express their any viewpoint on conversion therapy, sexual orientation, and gender identity.

Nor does the Ordinance limit the expression of opinions like the federal funding limitation at issue in *Legal Services Corp. v. Velazquez,* 531 U.S. 533, 121 S.Ct. 1043, 149 L.Ed.2d 63 (2001). In that case, the law prevented attorneys for legal assistance organizations who received government funding from challenging existing welfare laws. 531 U.S. at 548. The Supreme Court found that the purpose of the law was to "prohibit advice or argumentation that existing welfare laws are unconstitutional or unlawful." *Id.* at 547. Here, the licensed providers are free to advise minors on the purported benefits of conversion therapy and discuss their views on sexual orientation and gender identity. Again, the Ordinance regulates the practice of conversion therapy as defined by medical and mental health professionals, not the

Plaintiffs' views regarding the benefits of conversion therapy, gender identity, or gender expression.

E. Plaintiffs' Other First Amendment Claims Fail as a Matter of Law.

As the City detailed in its Motion for Summary Judgment and prior submissions before this Court, the Plaintiffs' other First Amendment claims fail as a matter of law. The Ordinance is not unconstitutionally vague, overbroad, or a prior restraint on speech.

1. *The Ordinance is Not Unconstitutionally Vague*

A plaintiff who claims that a law is unconstitutionally vague must prove either (1) the law fails to provide people of ordinary intelligence to understand what conduct the law prohibits or (2) the law authorizes or encourages arbitrary and discriminatory enforcement. *Konikov v. Orange Cty.*, 410 F.3d 1317, 1329 (11th Cir. 2005) (citations omitted). "[P]erfect clarity and precise guidance have never been required even of regulations that restrict expressive activity." *Ward v. Rock Against Racism*, 491 U.S. 781, 794 (1989). A statute is not unconstitutionally vague if "it is clear what the [the statute] as a whole prohibits." *Grayned v. City of Rockford*, 408 U.S. 104, 110 (1972).

Here, the language in the Ordinance is clear: It prohibits certain licensed practitioners from seeking to change a minor's sexual orientation or gender identity, it defines the practice of conversion therapy by certain licensed practitioners as unprofessional conduct, and it subjects them to discipline. Surely, a licensed practitioner who claims to support the practice of conversion therapy can understand the Ordinance's plain meaning. *See Pickup*, 740 F.3d at 1234.

2. *The Ordinance is Not Unconstitutionally Overbroad*

"[A] party [may] challenge an ordinance under the overbreadth doctrine in cases where every application creates an impermissible risk of suppression of ideas, such as an ordinance that delegates overly broad discretion to the decisionmaker. . . ." *Catron v. City of St. Petersburg*, 658 F.3d 1260, 1269 (11th Cir. 2011) (quoting *Forsyth Cnty. v. Nationalist Movement*, 505 U.S. 123 (1992)). The Supreme Court, however, has cautioned courts against finding a law overbroad and has instructed that the overbreadth doctrine should be employed by courts "sparingly and only as a last resort." *Broadrick v. Oklahoma*, 413 U.S. 601, 613 (1973). Because the Ordinance does not suppress Plaintiffs' expression of their ideas about conversion therapy, but rather only the practice of conversion therapy on minors, the Ordinance is not unconstitutionally overbroad.

3. *The Ordinance is Not an Unconstitutional Prior Restraint*

A prior restraint describes "administrative and judicial orders forbidding certain communications when issued in advance of the time that such communications are to occur." *Alexander v. United States*, 509 U.S. 544, 550 (1993). But Plaintiffs' argument fails because the Ordinance is a regulation of professional conduct that restricts speech only incidentally as "part of the practice of medicine."

Even if the Ordinance restricted protected speech, prior restraint on speech must be distinguished from a sanction for past speech. *Alexander*, 509 U.S. at 553–54 ("[O]ur decisions have steadfastly preserved the distinction between prior restraints and subsequent punishments."). Plaintiffs ignore this critical distinction. The Ordinance is not a prior restraint

because (assuming it even regulates speech) it does not regulate speech before it occurs. Instead, it penalizes providers after they have practiced conversion therapy on minors.

II. THE OPINIONS AND TESTIMONY OF DR. GLASSGOLD SHOULD NOT BE EXCLUDED

Plaintiffs challenge the opinion of Dr. Judith Glassgold that current scientific evidence, including those cited in the Ordinance "confirm unequivocally that conversion therapy (CT) in any form is ineffective and harmful." In essence, Plaintiffs argue that Dr. Glassgold, the Chair of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, the committee that produced the APA Report, cannot be relied upon to offer opinions concerning her own Task Force's conclusions, as well as subsequent research concerning the harm and ineffectiveness of conversion therapy. Plaintiffs fail to offer any evidence that Dr. Glassgold's opinions differ from the prevailing medical consensus of the psychological profession or otherwise apply unreliable methods. Instead, Plaintiffs' argument hinges upon select quotes from the APA Report taken out of context and omitting other portions of the Report, which fully support Dr. Glassgold's opinion. There is no basis to exclude this portion of the testimony of Dr. Glassgold, whom Plaintiffs had a full opportunity to cross-examine in her deposition.

Under Federal Rule of Evidence 702, expert witness testimony may be admitted if (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case. Fed. R. Evid. 702. This Court's gatekeeping function ensures that speculative and unreliable expert

testimony is not admitted. In that role, trial courts may consider a non-exhaustive list of factors such as whether the theory has been subjected to peer review and publication and whether the technique is generally accepted in the scientific community, which must be tied to the facts of a particular case. *Adams v. Lab. Corp. of Am.*, 760 F.3d 1322, 1327 (11th Cir. 2014). Dr. Glassgold easily satisfies the criteria for an admissible scientific expert opinion.

Plaintiffs do not dispute that Dr. Glassgold has the requisite scientific technical or other specialized knowledge to assist this Court. Rather, Plaintiffs attack her opinion that current scientific evidence confirms that conversion therapy is ineffective and harmful. Despite Plaintiffs attempts to characterize the medical consensus as "lacking empirical evidence to support any causal claims of harm," Plaintiffs cannot dispute that the nation's leading mental health organizations "publicly condemned the practice of SOCE, expressing serious concerns about its potential to inflict harm." *King v. Governor of the State of New Jersey*, 767 F.3d 216, 238 (3d Cir. 2014).

To be sure, "[a] court may conclude that there is simply too great an analytical gap between the data and the opinion proffered." *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146, 118 S. Ct. 512, 519, 139 L. Ed. 2d 508 (1997). But Dr. Glassgold's opinion relies on decades of peer-reviewed research, which concluded that any efficacy claims made by providers of conversion therapy are unsubstantiated. Her opinion also relies on scientific research demonstrating a clear association between conversion therapy and serious harms including suicidal ideation and suicide, and on the consensus of the leading national medical and mental health professional associations. This data is more than sufficient to support the admissibility her opinion under Rule 702.

III. PLAINTIFFS ARE NOT ENTITLED TO SUMMARY JUDGMENT AS A MATTER OF LAW ON IMPLIED PREEMPTION CLAIM

Plaintiffs' claim that the Ordinance is ultra vires and void ab initio because the Florida Legislature preempted the field of regulation of mental health professionals fails as a matter of law. Plaintiffs ignore the City's authority under its home rule powers to prevent mental health professionals from harming minors. The Supreme Court has recognized "the regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cty v. Automated Med Labs Inc*., 471 U.S. 707, (1985). As such, Florida explicitly authorizes municipalities to "exercise any power for municipal purposes except as otherwise provided by law." Fla. Const. art. 8 § 2(b). While Plaintiffs claim that Chapter 491 of Title XXXII of the Florida Statutes preempts the City's authority to enact the Ordinance, nothing in Chapter 491 expressly prohibits the City from imposing civil penalties on mental health providers. Instead, Florida Statutes § 456.003(2)(b) expressly authorizes municipalities to regulate professions for the preservation of health, safety, and welfare when "*[t]he public is not effectively protected by other means [such as] local ordinances.*" *Id.*

The Ordinance is not beyond the City's authority because the Legislature did not preempt the field of regulating mental health professionals and the Ordinance does not conflict with a state statute. *Sarasota Alliance For Fair Elections, Inc. v. Browning*, 28 So. 3d 880, 885–86 (Fla. 2010). There is no legislative scheme that is so pervasive as to evidence an intent to preempt the field of mental health professionals. Nor are there strong public policy reasons for finding that regulation of mental health professionals was preempted by the Legislature. Courts are cautious to input an intent that prohibits "a local elected governing body from exercising its home rule powers." *D'Agastino v. City of Miami*, 220 So. 3d 410, 421 (Fla. 2017)

(citation omitted). Because the Florida Legislature did not preempt the field of regulating mental health professionals, the City properly exercised in home rule powers in enacting the Ordinance to protect minors.

IV. PLAINTIFFS FAIL TO SATISFY ALL FACTORS FOR PERMANENT INJUNCTIVE RELIEF

Plaintiffs have failed to satisfy all the factors for permanent injunctive relief. "To obtain a permanent injunction, a plaintiff must show (1) that he has suffered an irreparable injury; (2) that his remedies at law are inadequate; (3) that the balance of hardships weighs in his favor; and (4) that a permanent injunction would not disserve the public interest." *Barrett v. Walker Cty. Sch. Dist.*, 872 F.3d 1209, 1229 (11th Cir. 2017).

First, Plaintiffs failed to establish that their right to speak is chilled by the Ordinance to establish irreparable injury. For the reasons stated above, the Ordinance applies to the Plaintiffs' conduct and Plaintiffs are free to speak about any topics including conversion therapy to their minor patients, parents, and the public at large. Second, since Plaintiffs have failed to establish that they suffered irreparable injury, the remedies at law are adequate. Third, the balance of hardships weighs in favor of the City in protecting minor children. Fourth, while the First Amendment is served in promoting First Amendment values, an injunction here would disserve the public interest by allowing a harmful and ineffective practice of conversion therapy to continue within the City limits. *See Suntrust Bank v. Houghton Mifflin Co.*, 268 F.3d 1257, 1276 (11th Cir. 2001) (stating that the public interest is served in promoting First Amendment values). Because Plaintiffs have failed to satisfy the factors enumerated by the Eleventh Circuit for a permanent injunction, this Court should deny summary judgment.

CONCLUSION

The Ordinance is designed to protect a vulnerable class—minors. While the First Amendment certainly needs protection, so too do children. Defendant, City of Tampa, respectfully requests that this Court deny Plaintiffs' Motion for Summary Judgment and to Exclude Certain Opinions of Dr. Glassgold and such further relief as is necessary to protect the City's rights.

Respectfully submitted

/s/ Robert V. Williams
Robert V. Williams
Florida Bar No. 144720
Dana L. Robbins
Florida Bar No. 106626
Primary: rwilliams@burr.com
Secondary: pturner@burr.com
BURR & FORMAN LLP
201 N. Franklin Street, Ste. 3200
Tampa, Florida 33602
Telephone: (813) 221-2626
Facsimile: (813) 221-7335
Attorneys for Defendants, City of Tampa

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 16th day of September, 2019, I caused a true and correct copy of the foregoing to be served via electronic mail on counsel for Plaintiff, Horatio G. Mihet (hmihet@lc.org), Roger Gannam (rgannam@lc.org), and Daniel J. Schmid (dscmid@lc.org).

/s/ Robert V. Williams
Attorney

Original Investigation

September 11, 2019

Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults

Jack L. Turban, MD, MHS[1]; Noor Beckwith, MD[2]; Sari L. Reisner, ScD, MA[3,4]; et alAlex S. Keuroghlian, MD, MPH[5,6]

Author Affiliations Article Information

JAMA Psychiatry. Published online September 11, 2019. doi:10.1001/jamapsychiatry.2019.2285

Key Points

Question Is recalled exposure to gender identity conversion efforts (ie, psychological interventions that attempt to change one's gender identity from transgender to cisgender) associated with adverse mental health outcomes in adulthood?

Findings In a cross-sectional study of 27 715 US transgender adults, recalled exposure to gender identity conversion efforts was significantly associated with increased odds of severe psychological distress during the previous month and lifetime suicide attempts compared with transgender adults who had discussed gender identity with a professional but who were not exposed to conversion efforts. For transgender adults who recalled gender identity conversion efforts before age 10 years, exposure was significantly associated with an increase in the lifetime odds of suicide attempts.

Meaning The findings suggest that lifetime and childhood exposure to gender identity conversion efforts are associated with adverse mental health outcomes.

Abstract

Importance Gender identity conversion efforts (GICE) have been widely debated as potentially damaging treatment approaches for transgender persons. The association of GICE with mental health outcomes, however, remains largely unknown.

Objective To evaluate associations between recalled exposure to GICE (by a secular or religious professional) and adult mental health outcomes.

Design, Setting, and Participants In this cross-sectional study, a survey was distributed through community-based outreach to transgender adults residing in the United States, with representation from all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and US military bases overseas. Data collection occurred during 34 days between August 19 and September 21, 2015. Data analysis was performed from June 8, 2018, to January 2, 2019.

Exposure Recalled exposure to GICE.

Main Outcomes and Measures Severe psychological distress during the previous month, measured by the Kessler Psychological Distress Scale (defined as a score ≥13). Measures of suicidality during the previous year and lifetime, including ideation, attempts, and attempts requiring inpatient hospitalization.

Results Of 27 715 transgender survey respondents (mean [SD] age, 31.2 [13.5] years), 11 857 (42.8%) were assigned male sex at birth. Among the 19 741 (71.3%) who had ever spoken to a professional about their gender identity, 3869 (19.6%; 95% CI, 18.7%-20.5%) reported exposure to GICE in their lifetime. Recalled lifetime exposure was associated with severe psychological distress during the previous month (adjusted odds ratio [aOR], 1.56; 95% CI, 1.09-2.24; $P < .001$) compared with non-GICE therapy. Associations were found between recalled lifetime exposure and higher odds of lifetime suicide attempts (aOR, 2.27; 95% CI, 1.60-3.24; $P < .001$) and recalled exposure before the age of 10 years and increased odds of lifetime suicide attempts (aOR, 4.15; 95% CI, 2.44-7.69; $P < .001$). No significant differences were found when comparing exposure to GICE by secular professionals vs religious advisors.

Conclusions and Relevance The findings suggest that lifetime and childhood exposure to GICE are associated with adverse mental health outcomes in adulthood. These results support policy statements from several professional organizations that have discouraged this practice.

Introduction

Transgender persons are those whose sex assigned at birth differs from their gender identity, the inner sense of their own gender.[1] According to a study by the Williams Institute,[1] approximately 1.4 million (0.6%) adults in the United States identify as transgender. Transgender persons in the United States experience a disproportionately high prevalence of adverse mental health outcomes, including a 41% lifetime prevalence of self-reported suicide attempts.[2-4]

Studies[5-7] have shown that gender-affirming models of care are associated with positive mental health outcomes among transgender people. Gender identity conversion therapy refers to psychological interventions with a predetermined goal to change a person's gender identity to align with their sex assigned at birth.[8] Several US states have passed legislation banning conversion therapy for gender identity.[8] Professional organizations including the American Medical Association,[9] the American Psychiatric

Association,[10] the American Academy of Child & Adolescent Psychiatry,[11] and the American Academy of Pediatrics[12] have labeled the practice unethical and ineffective. Despite these policy statements, however, the question of whether to ban gender identity conversion therapy remains a contentious policy debate.

State-level conversion therapy bans have been focused on gender identity conversion efforts (GICE) by licensed mental health practitioners. Nonlicensed religious advisors have also advertised GICE, and it is unknown whether GICE by these 2 groups of practitioners are distinct in their effects on mental health.[13]

Because gender identity is thought to be stable after puberty for most transgender persons, few have supported use of GICE after pubertal onset.[4] Some, however, have supported these efforts for prepubescent children, theorizing that gender identity may be more modifiable at this age.[14] Increasingly, this approach has fallen out of favor, with the growing understanding that gender diversity is not a pathologic finding that requires modification.[14] To our knowledge, there have been no studies evaluating the associations between exposure to GICE during either childhood or adulthood and adult mental health outcomes.

The current study used the largest cross-sectional survey to date of transgender adults living in the United States to assess whether recalled lifetime exposure to GICE is associated with adverse mental health outcomes, including suicide attempts. The study also assessed whether recalled childhood exposure to GICE before the age of 10 years is associated with adverse mental health outcomes in adulthood. We hypothesized that there would be associations between exposure to GICE by both secular and religious professionals and worse mental health outcomes.

Methods

Study Design and Data Source

The 2015 US Transgender Survey[15] is a cross-sectional survey that was conducted by the National Center for Transgender Equality (NCTE) between August 19 and September 21, 2015. It is the largest existing survey of transgender adults and was distributed via community-based outreach.[15] The US Transgender Survey protocol was reviewed and approved by the University of California Los Angeles institutional review board, Los Angeles, California. The US Transgender Survey data set was organized and recoded as described in the NCTE report on the survey.[15] The protocol for the present study was reviewed by the Fenway Institute institutional review board and was determined not to comprise human subjects research. Data analysis was performed from June 8, 2018, to January 2, 2019.

Study Population

The data set includes responses from 27 715 transgender adults residing in the United States, with representation from all 50 states, the District of Columbia, American

Samoa, Guam, Puerto Rico, and US military bases overseas. The NCTE report on the survey further characterizes recruitment strategies and the sample of respondents.[15] Because the organizations that conducted outreach for the survey did not systematically document the number of individuals reached by their outreach efforts, a response rate could not be calculated.

Exposures

The primary exposure of interest was an affirmative response to the binary survey question, “Did any professional (such as a psychologist, counselor, or religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?” This recalled exposure is herein referred to as GICE. Endorsement of lifetime exposure to GICE was examined among all those who confirmed having spoken to a professional about gender identity. Outcomes were compared among respondents who reported exposure to GICE before the age of 10 years with outcomes among those who endorsed lifetime exposure to therapy without GICE. Because the data set does not contain age of exposure to non-GICE therapy, participants with any lifetime exposure to non-GICE therapy were selected as the reference group in the analysis of those exposed to GICE before age 10 years. As data regarding ages of pubertal onset among respondents were not available, younger than 10 years was used as a cutoff to approximate a prepubertal population, with the understanding that there is significant individual variability in the age at onset of puberty.[16,17] Furthermore, we examined whether there was a difference in outcomes between those who reported exposure to GICE from a secular professional compared with those who reported exposure to GICE from a religious advisor.

Outcomes

We compared respondents with and without recalled exposure to GICE with regard to the following binary mental health variables: severe psychological distress during the previous month (defined as a score of ≥13 on the Kessler Psychological Distress Scale, a cutoff that has been previously validated in US samples[18]); binge drinking during the previous month (defined as ≥1 day of consuming ≥5 standard alcoholic drinks on the same occasion, a threshold for which the rationale in alcohol research among transgender persons has been discussed in previous reports[19]); lifetime cigarette and illicit drug use (not including marijuana); suicidal ideation during the previous year; suicidal ideation with plan during the previous year; suicide attempt during the previous year; suicide attempt requiring inpatient hospitalization during the previous year; lifetime suicidal ideation; and lifetime number of suicide attempts (0, 1, or ≥2).

Control Variables

Demographic and socioeconomic variables were collected and analyzed as defined in the US Transgender Survey, including sex assigned at birth, present gender identity, sexual orientation, racial/ethnic identity according to the recoded NCTE categories reflecting those typically reported in the American Community Survey, age (both in integer form and using US census categories to capture cohort effects), family support

of gender identity, relationship status (with *partnered* coded by these authors as binary and inclusive of both open and polyamorous relationships), educational achievement, employment status, and total household income. In supplemental analyses, we also controlled for exposure to sexual orientation conversion efforts undertaken by professionals.

Statistical Analysis

Analyses were conducted using SAS Studio, version 3.71, Basic Edition (SAS Institute). Participants were excluded from analyses if they did not report ever discussing their gender identity with a professional. Control variables were treated as unordered classification variables. Using the sample weights generated by the NCTE[15] to improve generalizability by addressing sampling biases around age, educational level, and race/ethnicity, we generated descriptive statistics for control and outcome variables. Bivariate analyses comparing responses from transgender adults were conducted based on (1) whether or not they had any lifetime exposure to GICE, (2) whether they had experienced GICE before age 10 years vs never, and (3) whether GICE were conducted by a secular vs religious professional. These bivariate analyses were performed to detect potential confounders to control for in subsequent regression analysis. Except for age, all variables were categorical; thus, we used Rao-Scott χ^2 tests for design-adjusted data with 1 *df* for bivariate comparisons. Age as an integer variable was nonnormally distributed; thus, bivariate comparison was performed with the nonparametric Mann-Whitney test. Standard errors and 95% CIs were calculated for the prevalence estimates of exposure to GICE using the aforementioned 1.4 million persons as the total population estimate.[1]

Multivariable logistic regression models were conducted to test whether GICE were associated with the outcomes, adjusted for variables with significant differences between groups in the preceding bivariate analyses. These models also used survey weights generated by the NCTE for age, educational level, and race/ethnicity. Adjusted odds ratios (aORs) with 95% CIs and 2-sided *P* values were reported, with a $P < .001$ threshold for significance.

Approximately 66 comparisons (between bivariate tests and logistic regression models) were made in each analysis. To reduce risk of type I error, a modified Bonferroni correction for multiple comparisons was performed, with resulting $\alpha = .001$ (ie, .05 divided by 50). Using the full number of comparisons yields only a slightly lower $\alpha = .0008$, which ultimately would not have altered the findings. We therefore selected an $\alpha = .001$ for both ease of reading and also the statistical consensus that unmodified Bonferroni correction tends to be maximally conservative, thereby unnecessarily inflating type II error.[20] Thus, hypothesis tests were 2-sided with corrected significance level $P < .001$ for both primary and secondary analyses, and the 95% CIs reported reflect this correction.

Respondents with missing data for exposure and outcome variables comprised less than 2% of the analytic samples and were therefore excluded without compensatory

methods, as is widely considered acceptable for this degree of data completeness.[21] Data were missing for less than 9% of each control variable, thereby obviating the need for imputation, which can introduce bias, especially when data are nonrandomly missing. There is debate about the degree of incompleteness that is acceptable without compensatory measures, and although individuals with incomplete data may be of particular interest, thresholds for missingness as high as 10% are considered to be acceptable.[22]

Results

Of the 27 715 US Transgender Survey respondents (mean [SD] age, 31.2 [13.5] years), 11 857 (42.8%) were assigned male sex at birth, and 3869 (14.0%; 95% CI, 13.3%-14.7%) reported exposure to GICE. Of 19 751 respondents who had discussed their gender identity with a professional, 3869 (19.6%; 95% CI, 18.7%-20.5%) reported exposure to GICE in their lifetime. Of these individuals, 1361 (35.2%; 95% CI, 32.7%-37.7%) who reported exposure to GICE stated that these were enacted by a religious advisor.

Demographic variables among exposed and unexposed respondents are shown in Table 1. After adjusting for statistically significant demographic variables, lifetime exposure to GICE was significantly associated with multiple adverse outcomes, including severe psychological distress during the previous month (aOR, 1.56; 95% CI, 1.09-2.24; $P < .001$) and lifetime suicide attempts (aOR, 2.27; 95% CI, 1.60-3.24; $P < .001$). (Table 2).

Overall, 206 (1.0%; 95% CI, 0.8%-1.2%) of those who reported discussing their gender identity with a professional also reported exposure to GICE before age 10 years. Demographics are shown in Table 3. After adjusting for statistically significant demographic variables, exposure to GICE before age 10 years was significantly associated with several measures of suicidality, including lifetime suicide attempts (aOR, 4.15; 95% CI, 2.44-7.69; $P < .001$) (Table 4).

Raw frequencies of outcome variables among exposure groups are shown in the Figure. There were no statistically significant differences in outcomes between those who were exposed to GICE enacted by religious advisors and those exposed to GICE by secular professionals (all aOR, $P > .001$) (eTable 1 and eTable 2 in the Supplement).

We also repeated all analyses adjusting for lifetime exposure to sexual orientation conversion efforts, defined as a positive response to the survey question, “Did any professional (such as a psychologist, counselor, or religious advisor) ever try to change your sexual orientation or who you are attracted to (such as try to make you straight or heterosexual)?” After this adjustment, both lifetime exposure (aOR, 1.96; 95% CI, 1.38-2.80; $P < .001$) and childhood exposure (aOR, 3.05; 95% CI, 1.55-6.02; $P < .001$) to GICE were associated with increased odds of lifetime suicide attempts but not with the other outcome variables (eTables 3 and 4 in the Supplement). Because this question was unclear regarding the referent gender (sex assigned at birth vs gender identity)

when defining sexual orientation conversion efforts, we refer to the models not adjusted for this variable throughout the article.

Discussion

This study was the first, to our knowledge, to show an association between exposure to GICE (lifetime and childhood) and adverse mental health outcomes among transgender adults in the United States. We found that recalled lifetime exposure to GICE was highly prevalent among adults: 14.0% of all transgender survey respondents and 19.6% of those who had discussed gender identity with a professional reported exposure to GICE.

The Generations Study[23] by the Williams Institute found that 6.7% of sexual minority group adults in the United States reported lifetime exposure to conversion efforts for sexual orientation.[23] Based on the findings of the current study, it appears that transgender people are exposed to GICE at high rates, perhaps even higher than the percentage of cisgender nonheterosexual individuals who are exposed to sexual orientation conversion efforts, although direct comparisons are not possible. One potential explanation for this is that compared with persons in the sexual minority group, many persons in the gender minority group must interact with clinical professionals to be medically and surgically affirmed in their identities. This higher prevalence of interactions with clinical professionals among people in the gender minority group may lead to greater risk of experiencing conversion efforts.

One study[24] showed that conversion efforts for sexual orientation were associated with an increased risk of depression and suicidal ideation. The current study was the first, to our knowledge, to find associations between any type of conversion efforts and both suicidal ideation and suicide attempts. A plausible association of these practices with poor mental health outcomes can be conceptualized through the minority stress framework; that is, elevated stigma-related stress from exposure to GICE may increase general emotion dysregulation, interpersonal dysfunction, and maladaptive cognitions.[25] Of note, having a lifetime suicide attempt was a more common outcome compared with severe psychological distress during the previous month, a result that was likely attributable to the time frames during which these variables were defined. Although this study suggests that exposure to GICE is associated with increased odds of suicide attempts, GICE are not the only way in which minority group stress manifests, and thus other factors are also likely to be associated with suicidality among gender-diverse people.

Respondents from more socioeconomically disadvantaged backgrounds (eg, low educational attainment or low household income) more commonly reported exposure to GICE. These individuals may have been more likely to receive GICE, or exposure to GICE may have been so damaging that they were impaired in educational, professional, and economic advancement. The cross-sectional nature of this study limits further interpretation. This finding warrants additional attention in the context of nationally

representative data showing lower educational attainment and lower income among transgender people in the United States compared with their cisgender counterparts.[26]

Given the considerable debate surrounding the merits of GICE for prepubertal youth,[4] we examined recalled early exposure to GICE (ie, before age 10 years) and found this to be less prevalent, with 1% of those who had ever discussed gender identity with a professional reporting that they had been exposed before age 10 years. Many experts have expressed concern that early exposure to GICE may lead to persistent feelings of shame because of physicians and parents defining gender-expansive experience as unacceptable.[4] A study[27] in Canada found a higher prevalence of shame-related feelings among youth treated with GICE. Both family and peer rejection of a child's gender identity have been associated with adverse mental health outcomes.[27-30] Extending those findings, the current study showed that recalled early exposure to GICE was associated with adverse mental health outcomes, including lifetime suicide attempts, compared with discussion of gender identity with a professional and no exposure to conversion efforts. Although not compared directly, the aOR of lifetime suicide attempts was higher for those exposed to GICE before age 10 years than the aOR for those with lifetime exposure, suggesting that rejection of gender identity may have more profound consequences at earlier stages of development. Further research is needed to better understand the associations between stage of development at time of exposure to GICE and risk of lifetime suicide attempts.

Our results support the policy positions of the American Academy of Child and Adolescent Psychiatry,[11] the American Psychiatric Association,[10] the American Academy of Pediatrics,[12] and the American Medical Association,[9] which state that gender identity conversion therapy should not be conducted for transgender patients at any age. Our finding of no difference in mental health outcomes between respondents who received GICE from a secular-type professional and those who received it from a religious advisor suggests that any process of intervening to alter gender identity is associated with poorer mental health regardless of whether the intervention occurred within a secular or religious framework.

Strengths and Limitations

Strengths of this study include its sample size, more than 90% completeness in the data set, and participants from a wide geographic area within the United States. Limitations include its cross-sectional study design, which precludes determination of causation. It is possible that those with worse mental health or internalized transphobia may have been more likely to seek out conversion therapy rather than non-GICE therapy, suggesting that conversion efforts themselves were not causative of these poor mental health outcomes. This interpretation, however, would also imply a mechanism whereby societal rejection leads to internalized transphobia and life-threatening adult mental health outcomes.

We also lack data regarding the degree to which GICE occurred (eg, duration, frequency, and forcefulness of GICE, as well as what specific modalities were used). If

a sizable proportion of those reporting exposure to GICE in the current study experienced relatively mild or infrequent conversion efforts, this might suggest the findings of this study are even more concerning (ie, even mild or infrequent conversion efforts were associated with adverse mental health outcomes, including suicide attempts). Because the survey question asked about exposure to GICE from professionals, it is possible that exposures to GICE from other people (eg, family members) were not captured. Although the survey included respondents from a wide geographic distribution across the United States, these participants were not recruited via random sampling. The sample may not be nationally representative. Data are also lacking regarding when respondents entered puberty, making it difficult to define a prepubertal sample; we therefore set an approximate prepubertal cutoff at age 10 years. In this study, we compared exposure to GICE before age 10 years with lifetime exposure to non-GICE therapy. Although it would have been ideal to compare the former group with those who experienced non-GICE therapy before age 10 years, we lacked data on the age at which respondents were exposed to non-GICE therapy.

Conclusions

The findings suggest that recalled exposure to GICE is associated with adverse mental health outcomes in adulthood, including severe psychological distress, lifetime suicidal ideation, and lifetime suicide attempts. In this study, exposure to GICE before age 10 years was associated with adverse mental health outcomes compared with therapy without conversion efforts. Results from this study support past positions taken by leading professional organizations that GICE should be avoided with children and adults.

Back to top

Article Information

Accepted for Publication: June 17, 2019.

Corresponding Author: Jack L. Turban, MD, MHS, Division of Child and Adolescent Psychiatry, Massachusetts General Hospital, Adult OPC, Mailstop 229, 115 Mill St, Belmont, MA 02478 (jack.turban@mgh.harvard.edu).

Published Online: September 11, 2019. doi:10.1001/jamapsychiatry.2019.2285

Author Contributions: Dr Beckwith had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Turban, Beckwith, Keuroghlian.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Beckwith, Reisner.

Obtained funding: Reisner, Keuroghlian.

Administrative, technical, or material support: Turban, Keuroghlian.

Supervision: Reisner, Keuroghlian.

Conflict of Interest Disclosures: Dr Turban reported collecting royalties from Springer for an upcoming textbook about pediatric gender identity. No other disclosures were reported.

Funding/Support: This work was supported by grant U30CS22742 from the Health Resources and Services Administration Bureau of Primary Health Care (Dr Keuroghlian), partly supported by a grant from the National Institutes of Health under award number UG3AI133669 (Dr Reisner), and an American Academy of Child and Adolescent Psychiatry Pilot Research Award for General Psychiatry Residents (Dr Turban).

Role of the Funder/Sponsor: The funding organizations had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The content is solely the responsibility of the authors and does not necessarily represent the official views of the Health Resources and Services Administration, the National Institutes of Health, or the American Academy of Child & Adolescent Psychiatry.

Meeting Presentation: This paper was presented at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry; October 25, 2018; Seattle, Washington.

Additional Contributions: We thank the National Center for Transgender Equality for sharing the data from the 2015 US Transgender Survey.

References

1.
Flores AR, Herman JL, Gates GJ, Brown TN. *How Many Adults Identify as Transgender in the United States*. Los Angeles, California: The Williams Institute; 2016.

2.

Beckwith N, McDowell MJ, Reisner SL, et al. Psychiatric epidemiology of transgender and nonbinary adult patients at an urban health center. *LGBT Health*. 2019;6(2):51-61. doi:10.1089/lgbt.2018.0136PubMedGoogle ScholarCrossref

3.
Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington DC: National Center for Transgender Equality; 2011.

4.
Turban JL, Ehrensaft D. Research review: gender identity in youth: treatment paradigms and controversies. *J Child Psychol Psychiatry*. 2018:59(12):1228-1243. doi:10.1111/jcpp.12833PubMedGoogle Scholar

5.
de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. 2014;134(4):696-704. doi:10.1542/peds.2013-2958PubMedGoogle ScholarCrossref

6.
Durwood L, McLaughlin KA, Olson KR. Mental health and self-worth in socially transitioned transgender youth. *J Am Acad Child Adolesc Psychiatry*. 2017;56(2):116-123.e2. doi:10.1016/j.jaac.2016.10.016PubMedGoogle ScholarCrossref

7.
Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016;137(3):e20153223. doi:10.1542/peds.2015-3223PubMedGoogle ScholarCrossref

8.
Byne W. Regulations restrict practice of conversion therapy. *LGBT Health*. 2016;3(2):97-99. doi:10.1089/lgbt.2016.0015PubMedGoogle ScholarCrossref

9.
American Medical Association. Health care needs of lesbian, gay, bisexual and transgender populations. H-160.991. 2017. https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml Accessed April 5, 2019.

10.
Byne W, Bradley SJ, Coleman E, et al; American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Report of the American Psychiatric Association Task Force on treatment of gender identity disorder. *Arch Sex Behav*. 2012;41(4):759-796. doi:10.1007/s10508-012-9975-xPubMedGoogle ScholarCrossref

11.
The American Academy of Child & Adolescent Psychiatry. Conversion Therapy. 2018. https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx. Accessed August 1, 2019.

12.
Rafferty J; Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4):e20182162. doi:10.1542/peds.2018-2162PubMedGoogle Scholar

13.
Salzman J. Colorado's Ban on "Conversion Therapy" Won't Stop the Catholic Church. *Rewire.News.* Published January 28, 2019. https://rewire.news/article/2019/01/28/colorados-ban-on-conversion-therapy-wont-stop-the-catholic-church/. Accessed August 1, 2019.

14.
Drescher J, Pula J. Ethical issues raised by the treatment of gender-variant prepubescent children. *Hastings Cent Rep*. 2014;44(suppl 4):S17-S22. doi:10.1002/hast.365PubMedGoogle ScholarCrossref

15.
James SE, Herman JL,Rankin S, Keisling M, Mottet L, Anafi M. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality; 2016.

16.
Herman-Giddens ME, Steffes J, Harris D, et al. Secondary sexual characteristics in boys: data from the Pediatric Research in Office Settings Network. *Pediatrics*. 2012;130(5):e1058-e1068. doi:10.1542/peds.2011-3291PubMedGoogle ScholarCrossref

17.
Herman-Giddens ME, Slora EJ, Wasserman RC, et al. Secondary sexual characteristics and menses in young girls seen in office practice: a study from the Pediatric Research in Office Settings Network. *Pediatrics*. 1997;99(4):505-512. doi:10.1542/peds.99.4.505PubMedGoogle ScholarCrossref

18.
Kessler RC, Green JG, Gruber MJ, et al. Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health (WMH) survey initiative. *Int J Methods Psychiatr Res*. 2010;19(suppl 1):4-22. doi:10.1002/mpr.310PubMedGoogle ScholarCrossref

19.
Gilbert PA, Pass LE, Keuroghlian AS, Greenfield TK, Reisner SL. Alcohol research with transgender populations: a systematic review and recommendations to strengthen future studies. *Drug Alcohol Depend*. 2018;186:138-146. doi:10.1016/j.drugalcdep.2018.01.016PubMedGoogle ScholarCrossref

20.
Sedgwick P. Multiple hypothesis testing and Bonferroni's correction. *BMJ*. 2014;349:g6284. doi:10.1136/bmj.g6284PubMedGoogle ScholarCrossref

21.
Dong Y, Peng C-YJ. Principled missing data methods for researchers. *Springerplus*. 2013;2(1):222. doi:10.1186/2193-1801-2-222PubMedGoogle ScholarCrossref

22.
Bennett DA. How can I deal with missing data in my study? *Aust N Z J Public Health*. 2001;25(5):464-469. doi:10.1111/j.1467-842X.2001.tb00294.xPubMedGoogle ScholarCrossref

23.
Mallory C, Brown TNT, Conron KJ. Conversion therapy and LGBT youth. Published January 2018. Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Jan-2018.pdf. Accessed August 1, 2019.

24.
DeLeon PH. Appropriate therapeutic responses to sexual orientation. Proceedings of the American Psychological Association, Inc, for the legislative year 1997: minutes of the annual meeting of the Council of Representatives. *Am Psychol*. 1998;53:882-939.Google ScholarCrossref

25.
Hatzenbuehler ML. How does sexual minority stigma “get under the skin”? a psychological mediation framework. *Psychol Bull*. 2009;135(5):707-730. doi:10.1037/a0016441PubMedGoogle ScholarCrossref

26.
Meyer IH, Brown TN, Herman JL, Reisner SL, Bockting WO. Demographic characteristics and health status of transgender adults in select US regions: behavioral risk factor surveillance system, 2014. *Am J Public Health*. 2017;107(4):582-589. doi:10.2105/AJPH.2016.303648PubMedGoogle ScholarCrossref

27.
Wallace R, Russell H. Attachment and shame in gender–nonconforming children and their families: toward a theoretical framework for evaluating clinical interventions. *Int J Transgenderism*. 2013;14(3):113-126. doi:10.1080/15532739.2013.824845Google ScholarCrossref

28.
Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs*. 2010;23(4):205-213. doi:10.1111/j.1744-6171.2010.00246.xPubMedGoogle ScholarCrossref

29.
Bockting WO, Miner MH, Swinburne Romine RE, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. *Am J Public Health*. 2013;103(5):943-951. doi:10.2105/AJPH.2013.301241PubMedGoogle ScholarCrossref

30.
de Vries AL, Steensma TD, Cohen-Kettenis PT, VanderLaan DP, Zucker KJ. Poor peer relations predict parent- and self-reported behavioral and emotional problems of adolescents with gender dysphoria: a cross-national, cross-clinic comparative analysis. *Eur Child Adolesc Psychiatry*. 2016;25(6):579-588. doi:10.1007/s00787-015-0764-7PubMedGoogle ScholarCrossref