

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
TAMPA DIVISION

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

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**PLAINTIFFS’ REPLY MEMORANDUM OF LAW IN SUPPORT OF  
MOTION FOR SUMMARY JUDGMENT AND  
MOTION TO EXCLUDE CERTAIN OPINIONS OF DEFENDANT’S EXPERT**

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,<sup>1</sup> pursuant to Local Rule 3.01 and the Court’s Case Management and Scheduling Order (D.183), file this reply memorandum of law in support of Plaintiffs’ Motion for Summary Judgment and Motion to Exclude Certain Opinions of Defendant’s Expert (D.194).

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<sup>1</sup> Plaintiff DAVID H. PICKUP, LMFT does not take part in this filing. (See D.188, Plaintiffs’ Certification of Conference to Narrow Issues for Summary Judgment.)

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## INTRODUCTION

As summary judgment briefing draws to a close, much has already been written. Plaintiffs’ legal arguments in support of their Motion for Summary Judgment and Motion to Exclude Certain Opinions of Defendant’s Expert (D.194, “Plaintiffs’ MSJ”), and Plaintiffs’ Memorandum of Law in Opposition to Defendant’s Motion for Summary Judgment (D.202, “Plaintiffs’ MSJ Opposition”), have already addressed much of the City’s argument in its Response in Opposition to Plaintiffs’ Motion for Summary Judgment and Motion to Exclude Expert Opinions (D.198, “Tampa MSJ Opposition”). Thus, Plaintiffs focus herein on the City’s failure to narrowly tailor its Ordinance—even to the faulty “medical consensus” it claims as justification—and the logical blunder made by the City in attempting to rescue Dr. Glassgold’s legally unreliable *ipse dixit* opinions.

## ARGUMENT

### **I. TAMPA’S ORDINANCE FAILS NARROW TAILORING BECAUSE IT BANS MORE THAN TAMPA’S FAULTY “CONSENSUS” OPPOSES.**

#### **A. “Consensus” of Organizations Without Empirical or Concrete Evidence of Harm Is Not a Constitutional Standard.**

As shown in Plaintiffs’ prior briefing, for strict scrutiny purposes Tampa cannot manufacture a compelling interest through merely anecdotal, speculative, or conjectural evidence of harm. (Pls.’ MSJ 7–9.) Rather, Tampa must bring empirical or other concrete evidence to satisfy its burden. (Pls.’ MSJ 7–9.) As Plaintiffs have also previously shown, amassing the unempirical positions of professional organizations does not meet this standard. (Pls.’ MSJ 7–9; Pls.’ MSJ Opp’n 2–4.)

Moreover, Plaintiffs have shown the Court that Tampa’s legislative judgments about a “medical consensus” are not entitled to deference. (Pls.’ MSJ Resp., D.202, at 3–4 (also citing prior argument).) When “[a] speech-restrictive law with widespread impact” is at issue, “**the**

**government must shoulder a correspondingly heavier burden and is entitled to considerably less deference in its assessment that a predicted harm justifies a particular impingement on First Amendment rights.”** *Janus v. Am. Fed’n of State, Cnty. & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2472 (2018) (emphasis added). Here, because the Ordinance infringes upon the free speech rights of licensed medical professionals, the government “must do more than simply posit the existence of the disease sought to be cured. **It must demonstrate that the recited harms are real, not merely conjectural.**” *Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 664 (1994); *see also Edenfield v. Fane*, 507 U.S. 761, 770 (1993) (regulation of professional speech must still demonstrate that the alleged harm is not “mere speculation or conjecture”); *Landmark Commc’ns, Inc. v. Virginia*, 435 U.S. 829, 841 (1978) (same). This is so because “[d]eference to legislative findings cannot limit judicial inquiry when First Amendment rights are at stake.” *Landmark Commc’ns*, 435 U.S. 843.

**B. Tampa’s “Consensus” Supposes “Conversion Therapy” Defined by Predetermined Outcomes Which Is Not the Therapy Provided or Referred by Plaintiffs.**

Even if the City had a compelling interest in banning the therapies opposed by its unempirical “consensus,” the Ordinance is not narrowly tailored to prohibit those therapies. (Pls.’ MSJ 12–16.) Whereas the First Amendment “demand[s] a close fit between ends and means.” *McCullen v. Coakley*, 134 S. Ct. 2518, 2534 (2014), the Ordinance is a blunt instrument banning far more speech than even Tampa’s faulty “consensus” could justify.

If the Court were relegated to counting noses (Pls.’ MSJ Opp’n 2–3), at best it would find a political consensus against the vague and undefined narrative of “conversion therapy,” which is long on rhetoric but short on details. (*See, e.g.*, Glassgold 71:12–25 (explaining her APA Task Force rejected the term “conversion therapy” because it is a lay term subject to misinterpretation and unintended connotations).) Close examination, however, reveals even the political

“consensus” is not talking about everything Tampa’s Ordinance bans. Throughout the APA Report, SAMHSA Report, and the various other position statements cited in the Ordinance, the objections are all directed to **therapies with a predetermined or a priori goal of changing sexual orientation or gender identity**. (See, e.g., Glassgold 58:20–60:1 (explaining “SOCE” term her Task Force coined for the APA Report 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.”); SAMHSA Report, D.24-4, PageID 544 (“Interventions **aimed at a fixed outcome**, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment.” (emphasis added)); SAMHSA Report, D.24-5, PageID 554 (same); SAMHSA Report, D.24-5, PageID 569 (“[C]onversion therapy, as well as any therapeutic intervention **with an a priori goal** for a child ‘s or adolescent’s gender expression, gender identity, or sexual orientation, is inappropriate.” (emphasis added)) (“Appropriate approaches support children and adolescents in identity exploration and development **without seeking predetermined outcomes** related to sexual orientation, sexual identity, gender identity, or gender expression.”); *American Psychiatric Association Position Statement on Psychiatric Treatment and Sexual Orientation*, D.24-1, PageID 359 (cited in Ordinance at D.24-1 PageID 344, 344 n.2) (“Therefore, APA opposes any psychiatric treatment, such as “reparative” or “conversion” therapy, that . . . is **based on the a priori assumption** that the patient should change his or her homosexual orientation.” (emphasis added)).) Tampa even claims in its MSJ opposition that “the purpose of the Ordinance is to prevent a

therapist from **imposing a predetermined outcome** on their minor patients . . . .” (Tampa MSJ Opp’n 15 (emphasis added).)

Contrast this derided “conversion therapy”—characterized by the therapist’s predetermined goal of changing sexual orientation or gender identity—with the talk therapy provided by Plaintiff Vazzo, which is client-directed, allows exploration of religious and sexual identities, and has no predetermined change goals.<sup>2</sup> (Pls.’ SUF ¶¶ 2–5.) Thus, the counseling Vazzo actually provides lines up with the counseling endorsed in the APA Report:

In terms of formulating the goals of treatment, we propose that, on the basis of research on sexual orientation and sexual orientation identity, **what appears to shift and evolve in some individuals’ lives is sexual orientation identity**, not sexual orientation. 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 provide a safe space where the different aspects of the evolving self can be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client, and it **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 Report, D.24-1, PageID 373 (emphasis added).) And:

Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE. Identity exploration is an active process of exploring and assessing

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<sup>2</sup> Vazzo uses the term “SOCE” to refer to counselling without predetermined change goals. (SUF ¶¶ 2–4.) Thus, Vazzo’s use of the SOCE term must be contrasted with its use in the APA Report and other publications where the term is intended to describe counselling provided by therapists who have predetermined change goals independent of client input. (*See, e.g.*, Glassgold 58:20–60:1 (explaining “SOCE” term her Task Force coined for the APA Report 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.”).)

one's identity and establishing a commitment to an integrated identity that addresses the identity conflicts **without an a priori treatment goal for how clients identify or live out their sexual orientation. . . .**

**LMHP [licensed mental health providers] address specific issues for religious clients by** integrating aspects of the psychology of religion into their work, including **obtaining a thorough assessment of clients' spiritual and religious beliefs, religious identity and motivations, and spiritual functioning;** improving positive religious coping; **and exploring the intersection of religious and sexual orientation identities.** This framework is consistent with modern multiculturally competent approaches and evidence-based psychotherapy practices and can be integrated into a variety of theoretical systems.

(APA Report, 24-2 PageID 432 (emphasis added).) And in the SAMHSA Report:

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, **behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.**

(SAMHSA Report, D.24-5 PageID 570 (emphasis added).)

According to the APA, facilitating a client's request for help modifying behavior, to avoid acting on same-sex attractions, is an acceptable course for therapists:

Some religious individuals may wish to resolve the tension between values and sexual orientation by choosing celibacy (sexual abstinence), which in some faiths, but not all, may be a virtuous path. We found limited empirical research on the mental health consequences of that course of action. Some clinical articles and surveys of individuals indicate that some may find such a life fulfilling; however, there are others who cannot achieve such a goal and might struggle with depression and loneliness. In a similar way, acting on same-sex sexual attractions may not be fulfilling solutions for others.

LMHP may approach such a situation by neither rejecting nor promoting celibacy but by attempting to understand how this outcome is part of the process of exploration, sexual self-awareness, and understanding of core values and goals. The therapeutic process

could entail exploration of what drives this goal for clients (assessing cultural, family, personal context and issues, sexual self-stigma), the possible short-and long-term consequences/rewards, and impacts on mental health while providing education about sexual health and exploring how a client will cope with the losses and gains of this decision.

(APA Report, D.24-2 PageID 429 (footnote and citations omitted).)

In short, Plaintiff Vazzo does not tell parents, “I’ll fix your kids,” or, “I’ll change your kids,” or, “I’ll cure your kids,” or even, “I’ll try to fix/change/cure your kids.” He has no predetermined or *a priori* treatment goal. Rather, Vazzo is open to facilitating client goals, including client change goals when they are voluntary and after informed consent. (Pls.’ SUF ¶¶ 2–5, FAVC ¶103.) This therapy approach is endorsed by Tampa’s “consensus”-makers.

So, why are we here? Because Tampa’s Ordinance—both as written and interpreted by Tampa—does not merely prohibit the “consensus” pariah “conversion therapy” with its predetermined change goals, but it also prohibits Vazzo’s talk therapy with its client-directed and client-defined goals because Vazzo is open to exploring changes in behaviors and attractions if desired by the client. (Pls.’ SUF ¶¶ 8–9.) It even prohibits client-directed and -requested change discussions expressly endorsed by the APA as critical: allowing a minor to return to a previous gender identity. (Pls.’ SUF ¶¶ 8–9, 22.)

Thus, even if the unempirical and speculative “consensus” against “conversion therapy” could supply a sufficiently compelling interest to justify Tampa’s speech ban—which it cannot—the Ordinance does not limit its prohibitions to the “conversion therapy” concept featured in the opposition literature composing Tampa’s “consensus.” Tampa fundamentally fails narrow tailoring because its speech ban goes too far, even farther than its faulty “consensus” could possibly justify.

**II. DR. GLASSGOLD’S ‘UNEQUIVOCAL SCIENCE’ AND ‘SIGNIFICANT RISK’ OPINIONS ARE LOGICALLY AND LEGALLY UNRELIABLE BECAUSE CORRELATION IS NOT CAUSATION.**

The City uses verbal sleight of hand to divert attention from the unreliability of Dr. Glassgold’s ‘unequivocal science’ and ‘significant risk’ opinions, as demonstrated in Plaintiffs’ MSJ. (Pls.’ MSJ 10–12.) Tampa cites nothing from the “research” referenced in the Ordinance, or any published since, to bridge the analytical gap between what the research actually says and Dr. Glassgold’s *ipse dixit* opinions that “current scientific evidence, including those cited in the [ordinance] findings, confirm unequivocally that conversion therapy (CT) in any form is ineffective and harmful,” and that “all forms of CT pose significant risks of harm.” (Glassgold Decl. (Dkt. 192-3) ¶¶ 14, 47.) Rather, Tampa simply claims Dr. Glassgold’s opinions rely on “decades of peer-reviewed research, which concluded that any efficacy claims made by providers of conversion therapy are unsubstantiated,” and “scientific research demonstrating a clear association between conversion therapy and serious harms . . . .” (Tampa MSJ Opp’n 21.) But “efficacy claims [that] are unsubstantiated” plus “clear association [with] harms,” no matter how often repeated, cannot “confirm unequivocally that conversion therapy . . . is ineffective and harmful.”

First, “unequivocally . . . ineffective” is not a logically valid conclusion from the actual evidence—that, *e.g.*, “research on SOCE . . . has not answered basic questions of whether it is safe or effective and for whom” (APA Rep. 90), and “research studies provide no clear indication of the prevalence of harmful outcomes . . . .” APA Rep. 42). To be sure, Dr. Glassgold testified that her APA Task Force considered a finding that “there is **no evidence** to support the use of psychological interventions to change sexual orientation,” but agreed instead to the finding that

“there is **insufficient evidence** to support . . .” (Glassgold 92:13–94:16 (emphasis added).<sup>3</sup>) And the conclusion “unequivocally . . . harmful” is logically invalid for the same reason—lack of evidence of efficacy or harm. To be sure, it is precisely the “decades of peer-reviewed research” that renders Dr. Glassgold’s ‘unequivocal science’ and ‘significant risk’ opinions manifestly unreliable. (Pls.’ SUF ¶¶ 11–14, 19–21, 36–40.)

Moreover, “unequivocally . . . harmful” is also an invalid conclusion to be drawn from a mere, unempirical “association between conversion therapy and serious harms” because “**correlation is not causation**, and as the Eleventh Circuit has held, the *post hoc ergo propter hoc* fallacy is not reliable enough to be allowed as expert testimony.” *McKee v. United States*, 1:11-CV-2526-RGV, 2014 WL 11460475, at \*6 (N.D. Ga. Jan. 15, 2014) (emphasis added) (internal quotation marks omitted) (italics in original), *aff’d*, 597 Fed. Appx. 625 (11th Cir. 2015).<sup>4</sup>

The Eleventh Circuit explained:

[S]imply because a person takes drugs and then suffers an injury does not show causation. Drawing such a conclusion from temporal relationships leads to the blunder of the *post hoc ergo propter hoc* fallacy.

The *post hoc ergo propter hoc* fallacy assumes causality from temporal sequence. It literally means “after this, because of this.” BLACK’S LAW DICTIONARY 1186 (7th ed.1999). It is

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<sup>3</sup> Dr. Glassgold affirmed at her deposition that no Task Force member objected to any part of the final 2009 APA Report. (Glassgold 89:3–20 (explaining they all “felt really good about it” and “felt very proud of it”).)

<sup>4</sup> See also *Alabama Gas Corp. v. Gas Fitters Local Union No. 548 of United Ass’n, AFL-CIO-CLC*, 2:13-CV-580-WKW, 2014 WL 3655713, at \*4 (M.D. Ala. July 23, 2014) (“It is axiomatic that correlation is not causation.”), *aff’d*, 599 Fed. Appx. 382 (11th Cir. 2015); *Manuel v. Pepsi-Cola Co.*, 17 CIV. 7955 (PAE), 2018 WL 2269247, at \*11 (S.D.N.Y. May 17, 2018) (“In law, as in science, ‘[c]orrelation is not causation.’” (modification in original) (quoting *Norfolk & W. Ry. Co. v. Ayers*, 538 U.S. 135, 173 (2003) (Kennedy, J., concurring in part and dissenting in part))), *aff’d*, 763 Fed. Appx. 108 (2d Cir. 2019); *Becerra v. Dr Pepper/Seven Up, Inc.*, 17-CV-05921-WHO, 2018 WL 1569697, at \*6 (N.D. Cal. Mar. 30, 2018) (“But correlation is not causation, neither for purposes of science nor the law.”).

called a fallacy because it makes an assumption based on the false inference that a temporal relationship proves a causal relationship.

*McClain v. Metabolife Intern., Inc.*, 401 F.3d 1233, 1243 (11th Cir. 2005). Dr. Glassgold’s ‘unequivocal science’ and ‘significant risk’ opinions—indeed, Tampa’s entire “consensus” narrative—make the same blunder, based on the false inference that correlation equals causation. Under binding precedent, this blunder is not allowable as expert testimony because it is not reliable.

The inability to draw causal conclusions was not only obvious from the literature cited in the Ordinance (Pls.’ SUF ¶¶ 11–14, 19–21), but is also expressly admitted in the later publications cited by Tampa and affirmed by Dr. Glassgold (*see, e.g.*, Ryan et al., Dkt. 142-3, Page ID 3234 (“[C]ausal claims cannot be made.” (emphasis added)) (Tampa MSJ Opp’n at 11) (Glassgold 151:16–155:5); Pls.’ SUF ¶ 36.) Even the newest “investigation” Tampa filed for the first time with its MSJ Opposition (Tampa MSJ Opp’n 15; D.198-1), which is thus outside the record, admits it cannot be cited for any causal conclusions:

**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. . . .**

**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**).

(Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, JAMA

Psychiatry (Sept. 11, 2019), doi:10.1001/jamapsychiatry.2019.2285, D.198-1, PageID 6852 (emphasis added).<sup>5</sup>)

It is beyond dispute that minors who identify as LGBT are at increased risk of poor mental health outcomes, including suicide and suicidal ideation. (*See, e.g.*, Declaration of Bernard O. Hudson, MD, D.191-7, ¶ 24.) It is also established that all therapy presents some risk of harm. (*See, e.g.*, Declaration of Christopher Rosik, Ph.D., D.191-2, ¶¶ 7, 17–21.) Is it also beyond dispute, however, that no study has quantified what increases to those risks—if any—are purportedly caused by “conversion therapy.” (Pls.’ SUF ¶¶ 12–14; Decl. Rosik ¶¶ 7, 17–21.) Thus, there is no reliable, empirical measure of risk causally attributable to “conversion therapy” that could logically or legally justify Dr. Glassgold’s *ipse dixit* opinions.

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<sup>5</sup> To be sure, the obvious bias and unreliability of the new Turban et al. “investigation” piece were quickly spotted:

Rarely have researchers been so explicit about the political aims of their research. If this study is really “the first study” to show “adverse mental health outcomes” related to “conversion therapy,” how can it be sufficient—even if it were high-quality—to justify government bans? And how could researchers have supported such bans prior to any study at all? Simple: it was never about science.

Mark Regnerus, *Does “Conversion Therapy” Hurt People Who Identify as Transgender? The New JAMA Psychiatry Study Cannot Tell Us*, *The Public Discourse* (Sept. 18, 2019), <https://www.thepublicdiscourse.com/2019/09/57145/?fbclid=IwAR0bSZbhV0sw5g7NxvUWWHmZ4Wy5O33mV1kpyt1BkGiDIYhGXJ48jKa38rw> (attached hereto) (quoting lead author’s statement, “We hope our findings contribute to ongoing legislative efforts to ban gender identity conversion efforts.”).

**CONCLUSION**

For all of the foregoing reasons, the Court should grant Plaintiffs' Motion for Summary Judgment.

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that on this September 23, 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  
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[Bioethics](#), [Culture](#), [Natural Law](#), [Philosophy](#), [Politics](#), [Religion](#), [Science](#), [Sexuality](#), [Transgender](#)

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## Does “Conversion Therapy” Hurt People Who Identify as Transgender? The New *JAMA Psychiatry* Study Cannot Tell Us

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September 18, 2019 By [Mark Regnerus](#)

A new study purports to prove the harms of “conversion therapy” for those who identify as transgender. But there are at least four good reasons for being leery of the results appearing therein.



In a “[study](#)” that arrived to much media fanfare last week in the journal *JAMA Psychiatry*, researchers affiliated with Harvard University and Massachusetts General Hospital purported to offer convincing proof that

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“conversion therapy” predicts longstanding toxic outcomes among Americans who self-identify as transgender, including greater recent suicidality and more severe psychological distress in the past month. Its results, the authors state, “support the policy positions” of such medical professional organizations as the American Medical Association and American Academy of Pediatrics.

I am agnostic on the topic of “conversion,” though I suspect the subject is more diverse and complicated than political soundbites let on. But I’m not agnostic about the new *JAMA Psychiatry* study. There are at least four good reasons for being leery of the results appearing therein.

**First**, the study fails to define or better distinguish what it means by GICE—that is, gender identity conversion efforts—its key variable and a term the authors appear to have invented. It comes from a solitary question that respondents were asked:

“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)?”

That’s what the survey asked. Given the hundreds of questions and items the United States Transgender Survey, or USTS, posed to its respondents, that it lumps any scenario that does not involve unqualified affirmation (including “watchful waiting” for minors) into one imprecise, binary measure is, I hold, psychometrically irresponsible.

Psychiatrist and longtime gender identity expert Stephen Levine highlights the quandary facing professionals attempting to [counsel transgender patients on the biological, social, and psychological risks](#) posed by any treatment approach. Such risks are real and ought to be discussed. This is what ethical informed consent does. But in the USTS survey lingo, an ethical discussion of risk could be interpreted by the patient as “trying to stop you being trans.” In other words, obtaining informed consent may

constitute GICE. It need not even stretch the imagination. Levine sees it. He notes that while the World Professional Association for Transgender Health endorses informed consent, this principle remains at odds with its recommendation of providing hormones on demand.

But the authors of the *JAMA Psychiatry* study, following the USTS's survey measurement, aren't interested in subtleties. The authors paint an entire class of cautious therapeutic approaches as intrinsically harmful, sending a clear message to psychiatrists and psychotherapists alike. Scientifically, we learn nothing of the respondent's motivations for interacting with the "professional" in the first place. It's not hard to understand how reality is far more complicated than the USTS data allow here. Their question can't distinguish between truly harmful approaches and potentially beneficial considerations.

**Second**, the data come from a nonrandom, opt-in survey—the USTS—that only targeted networked, self-identified transgender or nonbinary persons by advertising their survey among "active transgender, LGBTQ, and allied organizations." There's nothing wrong with collecting data using a nonrandom approach like this—I've done it myself and will do it again. The problem is when such data are delivered to the reader, as these were, in a way that suggests the conclusions would be consonant with everyone who has identified as transgender or experienced gender identity disorder or dysphoria. The survey's "United States" label further creates the impression that the data collection effort was a population-based random sample, sort of like the US Census. It is not. And you can't extrapolate the results of a non-random sample to the general population as a whole. (But you can hope that the media and readers will.)

When compared with [a 2017 study of the demographic characteristics of transgender adults](#) from the CDC's Behavioral Risk Factor Surveillance System—a genuinely population-based sample—the USTS respondents appear decidedly dissimilar. How different are they?

1. Unemployment: 15% in the USTS vs. 8% in the BRFSS
2. Sexual orientation: 47% of male-to-female identify as LGB in the USTS vs. 15% in the BRFSS; 24% of female-to-male identify as LGB in the USTS vs. 10% in the BRFSS
3. Currently married: 18% in the USTS vs. 50% in the BRFSS
4. Child in the household under 18: 14% in the USTS vs. 32% in the BRFSS
5. General health rated as fair or poor: 22% in the USTS vs. 26% in the BRFSS

To be sure, some of the questions were posed differently, but the differences here are not cosmetic. The two samples are at odds with each other. The *JAMA Psychiatry* authors employed “sample weights” that the USTS data creators designed “to improve generalizability by addressing sampling biases around age, educational level, and race/ethnicity,” but the notion of weighting such data makes little sense, since you cannot “generalize” an opt-in sample no matter what you do to it. The study treats the survey in the way its designers appear to desire—as if it were a population-based, representative sample of transgender Americans. But it isn’t. A simple acknowledgment of the sampling strategy and potential bias is small consolation, given the wide media coverage and attention the study has received.

**Third**, building on the dubious perception of representativeness, the authors report “confidence intervals” for their statistical “estimates.” Why they do so is beyond me. It’s a charade. Those terms are only truly sensible and appropriate for probability samples. A confidence interval, after all, is commonly used to indicate the probability that the “population parameter” (e.g., the true share of transgender persons reporting severe psychological distress) falls within the interval around the estimate generated by the sample you have. But if the sample you have isn’t representative of the population from which it was drawn—something the above comparison between the USTS and BRFSS strongly suggests—then it’s pointless to use

these terms. Saying so suggests you have statistical rigor when you do not. Hypothesis testing, using *P* values, seems an odd approach under these circumstances.

It is no small irony that just one month earlier *JAMA Psychiatry* published an opinion piece by Helena Chmura Kraemer, Stanford University biostatistics professor and fellow of the American Statistical Association, entitled, "[Is it Time to Ban the \*P\* Value?](#)" She makes a compelling case, in light of what the Harvard researchers are attempting to accomplish:

For more than 20 years, there have been rumbles about banning the *P* value, because it is so often misused, miscomputed, and, even when used and computed correctly, misinterpreted. Consequently, findings that affect medical decision-making, policy, and research are often misled by the very research that is supposed to provide their evidence base.

Well put.

**Fourth**, the authors seem largely uninterested in putting their implied causation—that past conversion attempts affect present mood and suicidality—to the test. Instead, a subtext of injustices committed against the respondents infuses the study, suggesting a decidedly external locus of control in the lives of transgender Americans. This narrative is only interrupted once, when to their rare credit the authors admit that 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." I think the average reader would believe this is probable, not just possible.

By way of comparison, the relative risk of attempting suicide among women currently or recently using hormonal contraceptives—a monumentally larger share of the overall population—[is demonstrably](#)

[higher](#) than those who do not. And yet no medical organization is calling for stripping access to the Pill. Instead, the authors of the study reporting those findings suggest that we should work to understand better why women seek contraception when they do, as well as exploring why it may prompt the development of adverse mood reactions. That's what curious investigators do. No similar quest appears to characterize the *JAMA Psychiatry* article, which never explores why a portion of the USTS respondents found themselves in an office listening to cautious therapeutic counsel—something now considered dubious if not outright banned. This lack of intellectual curiosity is unfortunate, the hallmark of an utterly politicized science whose bar for publishing studies on a topic now exploding in popularity is much too low.

When the study was released, Dr. Jack Turban—the lead author—was unabashed about its novelty. As [NBC Out covered](#) it, Turban claimed “it was the first study ‘to show that gender identity conversion efforts are associated with adverse mental health outcomes, including suicide attempts,’” and that “previous reports showing the negative effects of conversion therapy . . . have focused on efforts to change a person’s sexual orientation,” rather than gender identity. Turban then turned to its political and legal value:

“This is important because some experts continue to advocate for gender identity conversion efforts for young children,” Turban said in a statement. “We hope our findings contribute to ongoing legislative efforts to ban gender identity conversion efforts.”

Rarely have researchers been so explicit about the political aims of their research. If this study is really “the first study” to show “adverse mental health outcomes” related to “conversion therapy,” how can it be sufficient—even if it were high-quality—to justify government bans? And how could researchers have supported such bans prior to any study at all? Simple: it was never about science.

I do not wish to make light of the suffering of self-identified transgender persons. It is, from all discernible sources, significant. Nor am I claiming that various forms of therapy are helpful or unhelpful, ethical or unethical. My conclusion is more modest. Weak data are being used to make empirical—and then clinical and legal—truth claims while subsidized by nascent political will. Discerning a generalizable answer to ethical questions about “conversion” therapy from the *JAMA Psychiatry* study is simply not possible, despite what its authors confidently assert and imply. Theirs is what Professor Kraemer would probably call a “hypothesis-generating” study, not a “hypothesis-testing” one. But you wouldn’t know it from reading it.

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## About the Author



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